The Canadian Nurse

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Between Ourselves

Long before this issue reaches you, many hundreds of Canadian nurses will have had an opportunity to participate in the ***welcoming celebrations*** arranged for **Their Royal Highnesses, Princess Elizabeth and Prince Philip.** We know that they will enjoy the scenic variety our vast country has to offer. We hope that their entire visit will be a happy event in the lives of all of us.

* * *

How "cool and collected" are you in the face of an emergency? Are you among the 12 to 25 per cent of individuals who can maintain an emotional imperturbability and function smoothly and efficiently? Logically, to be of greatest service under such conditions, every nurse should be able to control her reactions sufficiently to give the expert assistance that is demanded at the time of an emergency.

Dr. T. E. Dancey has summarized very clearly and concisely what the probable results of a ***mass disaster*** would be. This is an extremely important aspect of Civil Defence. Every nurse should read this article and discuss its contents. Do not leave it to the few conscientious souls who read the *Journal* from cover to cover each month. With many hundreds of nurses dependent on someone else's copy, we urge you to share yours so that every nurse will be awake to her responsibilities, even if they are no more involved than the necessity to be a good listener. Perhaps the task might include being a "substitute mother" should the evacuation of children from possible target areas ever become a reality. Analyze your own reactions now and be ready for any eventually.

* * *

A new day always dawns in the east. Perhaps it is significant, therefore, that **Dr. H. B. Atlee's** suggestion for a more ***humane type of maternity hospital*** comes from one of our most easterly cities — Halifax. Though it is not yet a *fait accompli* the proposed new deal in obstetrical care may well spread from the east throughout the rest of Canada. Most nurses have little opportunity to contribute suggestions to the planning and construction of hospitals. Yet all of us are interested in them. Every year hundreds of nurses take a busman's holiday by visiting other institutions than their own. They pick up new ideas which they can pass on. This article serves in place of a visit. Tell your obstetricians and those charged with hospital construction plans about it.

* * *

Children's Hospital in Winnipeg solved the problem of how to shift from a hospital day beginning at 7:00 a.m. to one that starts at 8:00 a.m. **M. Kathleen Ruane** tells us how it was done. The increased satisfaction of patients and staff alike would indicate that it is a pattern that would be well worth copying.

We are told that the biggest problem such a ***change of hours*** would pose lies in the dietary department. Breakfasts would have to be served later thus throwing the whole day out of kilter. No such dislocation need occur if the full cooperation of every department is ensured through conferences, planning, and discussion *before* the change is launched.

What other hospitals in Canada are operating on these new hours? We would be interested in hearing from them and the problems they had to overcome. We will share such information as we may receive with our readers.

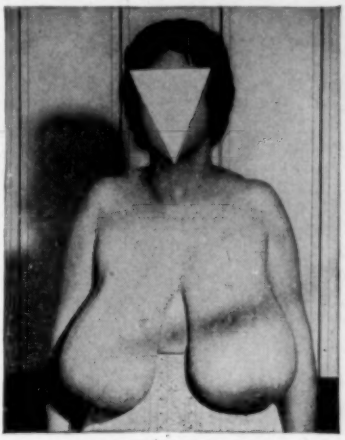
* * *

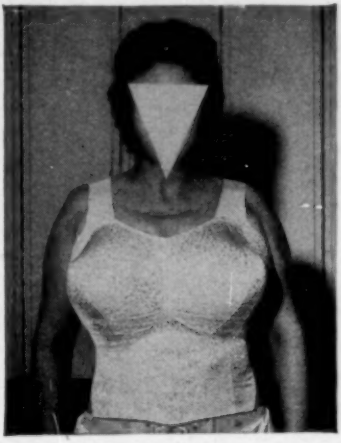
There is a close relationship between the new service described by **Wilma A. Howes** and the familiar picture of good ***visiting nurse care*** outlined by **Margaret Oulimar.** For several months now, the Victorian Order of Nurses, Montreal Branch, has been providing expert care for the patients being discharged from the Herbert Reddy Memorial Hospital. Where good home facilities exist, it is a sound solution to overcrowded wards.

* * *

Though various other experiments in modernizing the educational programs in schools of nursing are being demonstrated in Canada, any move to introduce the ***"central school"*** pattern is still only in the discussion stage. **Gertrude M. Hall's** vigorous style will clarify the thinking of those whose conception of this project is still nebulous.

It is as impossible for a man to be cheated by anyone but himself, as for a thing to be, and not to be, at the same time. — EMERSON





*". . . the pendulous breast may exert pressure on the diaphragm, heart and lungs"**

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*LaRoe, Else K., *Care of the Breast,* Froben Press, New York, 1947.

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Administration—1 to 2 repeated as required and prescribed. For insomnia and other conditions requiring timing of action the appropriate dose may be given 60 to 90 minutes before full effect is desired.

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Manufacturer—Charles E. Frosst & Co., Montreal.

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DIGITISOL TABLETS

Manufacturer—Nadeau Laboratory Ltd., Montreal.

Description—Each tablet represents: Digitoxin 0.2 mg.

Indications—As for digitalis leaf.

Administration—One tablet exerts the same action as 0.2 gm. standard powdered digitalis.

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Manufacturer—Canada Pharmacal Co., London, Ont.

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SUDROMA Solution

Manufacturer—Charles E. Frosst & Co., Montreal.

Description—Therapeutically active water-soluble derivatives of Chlorophyll "a" in isotonic saline solution.

Indications—For deodorization and treatment of wounds, burns, chronic ulcers, dermatitis, impetigo, and whenever acceleration of tissue repair is desired.

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Manufacturer—Rexall Drug Co. Ltd., Toronto.

Description—Each troche contains: 3,000 I.U. Potassium Penicillin G Crystalline in a special fast release; pleasantly flavored base.

Indications—For use in the treatment of sore throat, Vincent's infection, and other oral conditions where penicillin is indicated.

Administration—For topical application, by allowing one tablet to dissolve slowly in the mouth every 4 hours or as directed by the physician.

E-GESTROL

Manufacturer—Barlow-Maney Laboratories Ltd., Hamilton.

Description—Each cc. contains Progesterone 25 mg. and Vitamin E as d, 1,-alphatocopherol acetate 50 mg. in purified sesame oil.

Indications—Suggested for use in recurrent and threatened abortions. Contraindicated in missed or incomplete abortions.

Administration—Intramuscularly.

National Immunization Week — 1951

For the ninth consecutive year, the Health League of Canada is sponsoring a Canada-wide educational campaign to call to public attention the dangers of such preventable diseases as diphtheria, whooping cough, tetanus, and smallpox and the means for their prevention. National Immunization Week will be observed *from October 14 to 20.*

Last year there were 305 deaths from 12,182 cases of whooping cough and 49 deaths from 421 cases of diphtheria — a tragic and unnecessary waste of life, according to the Health League of Canada.

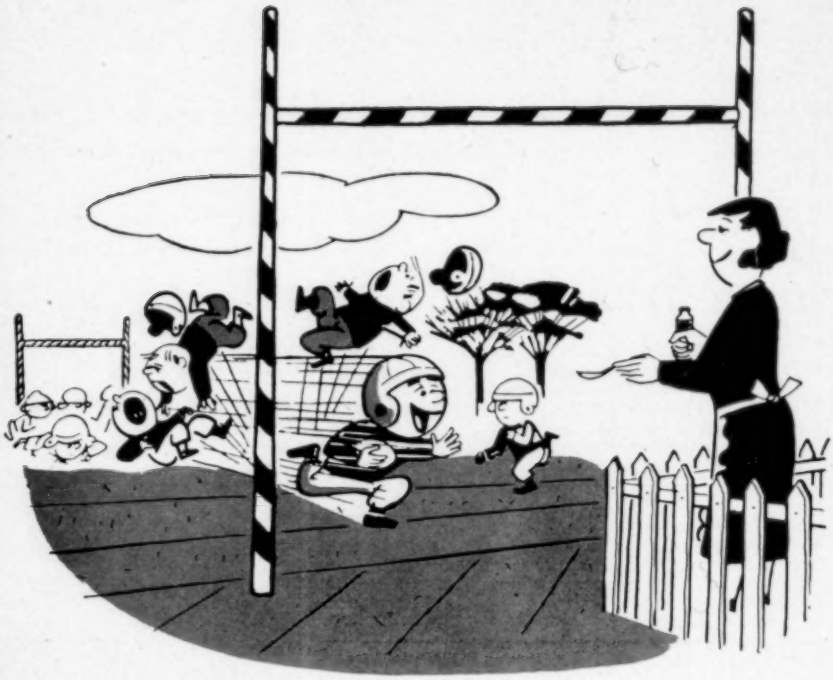
The Health League of Canada points out that both of these diseases are preventable — through diphtheria toxoid and whooping cough vaccine, respectively. Health departments and family doctors throughout the country are able and willing to provide this protection against these two diseases, yet both continue to take annual toll among Canada's children.

Dr. Collins-Williams, medical director of the Child and Maternal Health Division of the Health League, states that of contagious diseases among children under one year of age, whooping cough was the leading cause of death.

The Health League advises that tetanus is also preventable by toxoiding and should only be of historic interest in these enlightened times.

Each year in every province of Canada children die from preventable diseases, indicating the need for continued vigilance on the part of health authorities to publicize the necessity of universal immunization, according to leading pediatricians. "Medical science has provided the means to wipe out these diseases — it is up to the general public to take full advantage of the preventives and the facilities provided for their use."

—*Health League of Canada*



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The
CANADIAN NURSE

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PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION

VOLUME FORTY-SEVEN *NUMBER TEN*

MONTREAL, OCTOBER, 1951

An Ottawa Conference

Average reading time — 4 min. 24 sec.

THIS IS THE REPORT of a three-day conference which took place in Ottawa on June 11-13, 1951. Arrangements for the conference were made by the Core Advisory Committee on Nursing to the Civil Defence Health Planning Group and those attending were the Canadian nurses who had taken a course in the United States on "The Nursing Aspects of Atomic, Biological and Chemical Warfare."

The main purpose of the conference was to plan a standardized course on A.B.C. warfare for the training of nurses and auxiliary nursing personnel throughout Canada.

On the first morning, Miss Dorothy Percy, chairman of the conference and also chairman of the Core Advisory Committee on Nursing, opened the conference by introducing the Hon. Paul Martin, Minister of National Health and Welfare. After welcoming the nurses, Mr. Martin spoke of the role of his department in Civil Defence and its link with the provincial and municipal Civil Defence authorities. Speaking in a forceful, sincere manner, Mr. Martin impressed one with his vision and purpose.

Captain Jack Wallace of the Training Section of Civil Defence further

MARY E. HENDERSON

Miss Henderson is educational director with the Metropolitan Health Committee, Vancouver, B.C.

amplified the administrative organization of Civil Defence on the national level and made special mention of the Training School for Civil Defence and the various types of training for Civil Defence now being given at the school.

Dr. K. C. Charron, chief of the Civil Defence Health Planning Group, then addressed the meeting. He spoke of the duties of the Health Planning Group in initiating and coordinating plans and developing a general pattern as a guide for the provinces. The need for basic uniformity was stressed in connection with the mutual aid policy between cities, municipalities, and provinces in our own country and also between American and Canadian centres. Dr. Charron outlined the plan to send out two travelling teams to certain centres in Canada to conduct four-day courses for nurses of "instructor calibre" in the nursing aspects of A.B.C. warfare, with the intention that these nurses in turn would teach nurses in their own areas. He described the various "Working Parties"—e.g., Casualty Services, Laboratory Services, Sanitation Services for which descriptive manuals are being prepared.

Following Dr. Charron's address, Miss Percy spoke in more detail of the plan for the two travelling teaching teams. It is anticipated that these teams will start out from Ottawa—one travelling westward and one eastward—giving the course in the centres selected. Personnel of the teams will probably include a doctor, a scientist, one or two nurses, and secretarial help. It is hoped that the nursing coordinator will be able to visit the provinces this fall, preceding the teams to advise the provinces regarding preparations and to "set the stage." She will aid the provincial nurses' associations and provincial Civil Defence authorities in the necessary planning for the courses. At each course a complement of approximately 70 "instructors" will receive the training. The provinces will be responsible for choosing their representatives to attend the course.

Miss Percy then called upon the nurses present for brief reports on Civil Defence preparations in their respective provinces. Following this we returned to the main purpose of the conference, namely:

1. To evaluate the proposed Manual of Instruction and to recommend changes, deletions, and additions.
2. To discuss the content of the course for service groups of graduate nurses who will be taught by the nurse instructors; and to discuss training for auxiliary aides.
3. To consider the role of the nurse in Civil Defence.

The Manual was presented to the group by Miss Groenewald who described it as a "foster child," who had been unloved at first, but who had gradually eased its way into the hearts of its "foster mothers." We soon realized that it was a "foster child" of which the "foster mothers" could well be proud.

For study of the Manual and discussion of other aspects of the task in hand, the larger group was divided into three groups of about eight. In these three sections members analyzed the Manual in detail, recording suggested changes, parts needing further clarification, additions, etc. Then the whole group re-assembled to discuss the recommendations. In consideration of some of the material, Dr. Guest, senior scientific adviser, Radiological Training Section, Industrial Health Division of the Department of National Health and Welfare, and Dr. Watkinson, medical health officer of this same Division, kindly acted as consultants.

The course to be taught to the service groups of graduate and student nurses and the course for auxiliary aides were also discussed. Further work is to be done on the course content for these groups by the Core Advisory Committee on Nursing.

On the last afternoon, Miss Agnes Macleod discussed the question of a registration of nurses which it is hoped may be launched shortly. The purpose of such a registration is to determine the potential nursing strength of our country. The type of questionnaire to be used is receiving careful consideration.

Dr. Charron closed the conference

with a look towards what this planned training of nurses would eventually accomplish—nurses throughout Canada ready to meet disaster with the security which knowledge and preparedness bring.

In concluding this report, I might add that, looking back over the conference, the members seemed to have that feeling of satisfaction which accompanies the successful accomplishment of a purpose. Representatives from the provinces felt privileged to have had a small part in this "national planning."

—MARY E. HENDERSON

A More Humane Type of Maternity Hospital

H. B. ATLEE, M.D., F.R.C.S.

Average reading time — 14 min. 24 sec.

IT IS THE contention of this brief article that, if having a baby is the most important thing any woman can do, the architecture of the modern maternity hospital has not yet caught up with that idea. I refer in particular to the architectural failure to recognize having a baby as a natural and not a pathological process, and so to provide fully and adequately for the laboring woman during *all* the stages of her labor.

Obstetrical hospitals were originally designed to deal with the abnormalities of delivery. Women were not admitted to them until such an abnormality had arisen. As a result, the main architectural emphasis was on providing suitable accommodation for the actual delivery itself. A great change has occurred within recent years in the manner in which women use maternity hospitals. Instead of using them merely for their difficult or complicated labors, they now use them for all their labors, and they enter hospital *at the very beginning of these labors.*

The doctor finds it more convenient to have his patient in hospital early in labor. Her husband and relatives want to get her off their hands at the earliest possible moment because of their fears that some complication might arise in the home which they would not be able to handle. But there has been no change in hospital design to deal either efficiently or humanely with this changing modern situation. Furthermore, since maternity hospitals were originally designed to deal with the complications of labor, their whole philosophy is based on pathology. But labor is a natural, or physiological process in the vast majority of cases, and not a pathological one. So the situation in maternity hospitals today is this: that whereas in the past most of the cases admitted were complicated by pathological conditions, today all but a small number are normal and uncomplicated.

It is important to stress this difference. Unless we do so we will continue to think of hospital accommodation for the laboring woman in the same terms that we think of such accommodation for a woman with gallstones. *We must get away from the concept that what is good enough in hospital accommodation for the woman with gallstones is good enough for the woman having a baby.* The woman with gallstones has only one gallbladder to lose and any inconvenience she suffers through hospital design is not vital. But labor, for racial

Dr. Atlee is with the Department of Obstetrics and Gynecology, Dalhousie University, Halifax.

reasons, must be repeated—at least three times if we are to preserve our population and more if we are to increase it. Thus the hospital providing this service must be so designed and managed that the average woman will look back on her handling while in it with nothing but satisfaction and pleasure.

This is true neither of the design nor the management of maternity hospitals at present. This is the sort of thing that happens. Because of the lack of proper space to accommodate her during the long first stage of labor, Mrs. A. is admitted to the delivery section immediately—often in the middle of the night when her courage is not at its best. She is given a hypo of synkayvite, an enema and a bath, and put into a room—often a very small, very bare and cheerless room—and left there hours on end. Or she may be put into a room with Mrs. B., in a later stage of labor, who is crying out with her contractions. Unable to move about because of the size of the room, Mrs. A. is confined to bed long before this is truly necessary. She lies there alone with her fear and her pain. She can't have her husband or friends in to see her because this is sacredly sterile territory from which these germ-laden aliens must be excluded.

Is it any wonder Mrs. A. becomes frightened as the contractions increase in strength? That with increasing fear she becomes more and more tense? That with increasing tenseness she feels her pains more bitterly than she would if she were confident and relaxed? The cries of other women who are farther along in labor add to her terror. Perhaps she has been given no instruction as to what is going on inside her, with the result that so simple a thing as rupture of the membranes may convince her she has burst her bladder. So she cries out for relief long before she otherwise would and is given a sedative. Later, when its effect wears off, she cries out for more until by the time she is ready to be delivered she and her baby are so seriously doped as to be in danger.

Is it only a coincidence that women have required more sedatives during labor since they have started entering hospital earlier in labor? Or do they require more sedation because the modern maternity hospital provides no facilities that would obviate this? What is there against laboring women having sedatives. Three things:

1. Under the sedative the laboring woman cannot help the obstetrician because she cannot respond to command.

2. Babies of over-sedated mothers die because they too are sedated at birth and so do not respond well to the stimulus to breathe. In some cases it takes a lot of effort and time on the part of the doctor to get them breathing. We know that the possibility of permanent brain cell damage increases in geometrical proportion with the length of time it takes to get a baby breathing normally.

3. The woman who is over-sedated or anesthetized during any length of her labor loses a good deal of the psychological satisfaction of having had a baby. She becomes a more or less inert and neutral factor in the birth — and feels this subconsciously. Her memory of labor is of a vague, pain-stirred wasteland; she has been denied the satisfaction of having played a really active and valiant part in this most outstanding and important act that a human being can perform.

I am convinced, as a result of a two years' trial, that, without increasing the woman's sufferings, the amount of sedative required by her can be cut to a minimum that will be neither dangerous to herself nor to her baby. What is more, she can go through the long first stage of labor with much more *élan*—and without realizing its length—if she can be diverted by being able to walk about, talk to her husband and friends, listen to the radio, etc. With this type of diversion, labor can be remembered not as a painriven and lonely wasteland, but rather as a sort of social event. Women can renew that self-respect they lost during the Twilight Sleep era of the '20's and '30's, when they retreated into obstetrical escapism and derived little real satisfaction out of the process of bearing a baby.

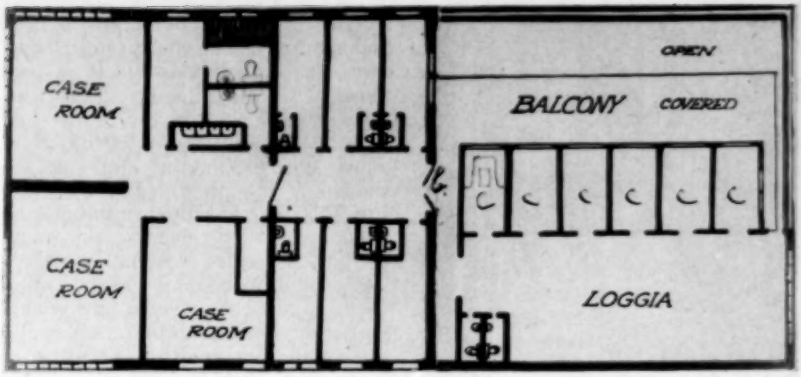

Fig. 1

To accomplish this we must redesign our maternity hospitals with a view to providing those architectural facilities that will allow for the proper exercise and diversion of the laboring woman during her long first stage of labor, leaving the delivery section more or less as it is to handle the short last stage. In order to do this effectively the following desiderata must be met:

1. The first stage of labor should be handled in a different section of the hospital than the actual delivery suite.
2. This section should be on the same floor as the delivery suite and in close proximity so that patients can be moved rapidly and easily from one to the other.
3. The section for handling this first stage should provide the following facilities:

(a) Opportunity for each patient to have her husband and/or her friends with her during this stage and to do so with a reasonable degree of privacy.
(b) Radio if requested.
(c) Opportunity for perambulation over a reasonable area and not merely up and down a tiny room.
(d) Opportunity to perambulate out of doors in all but the most inclement weather.

With these desiderata in mind some time ago I drew out roughly my idea of their architectural fulfilment and had a student artist draw them properly. They are embodied in the four accompanying photographs. It must be emphasized that they represent merely the idea and not the final design.

The plan in *Fig. 1* shows the essential lay-out for the entire handling of all stages of labor. Let us call the part to the right of the doorway (*b*), the First Stage Section, and the part to the left—the Delivery Section. In the plan shown in *Fig. 1* they are separated only by the barrier and door (*b*) but in our final plan a hallway or corridor will be between the two sections. The two sections, therefore, while definitely separated from one another, are so close that a patient can easily and quickly be moved from the First Stage to the Delivery Section.

The First Stage Section is divided into three parts: (1) individual rooms (*c* in *Fig. 1*), (2) a loggia and (3) a balcony, partly covered. The individual rooms (*Fig. 2*) open on the loggia. They are small and soundproof.

Fig. 2

All photos courtesy of Victoria General Hospital Photo Dept.

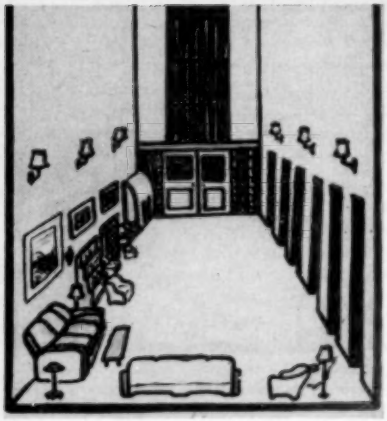

Fig. 3

Each contains wiring for a radio. There are wall couches along the window and half of each side. There is room for a table the size of a card table, and can hold the patient and three other people comfortably, (9′ x 10′). Each patient, public or private, will have one such room for use while she is in the first stage of labor. Husband and friends will be admitted to this section freely and will be encouraged to come, as their presence will help to divert and relax the patient.

The loggia should ideally have a higher ceiling than the rest, since it is for perambulation, and would convey less sense of claustrophobia and more sense of space (and, therefore, tend to relaxation). It is provided with toilet facilities. Its windows should be of the plate-glass picture type (with some sash type to allow for ventilation) and not as shown in the photo (*Fig. 3*). It is furnished so that the perambulating woman can sit down when she wants to and provides reading matter—books and magazines. The balcony (*Fig. 4*) is partly covered and is likewise for perambulation, especially during the hot months. We feel that it should be used throughout the year except in the most inclement weather, since the extra oxygenation of her blood would be good not only for the woman but for her child.

It will be noted that in both loggia and balcony we stress provision for perambulation. We do so for two reasons:

1. Those of us who remember delivery in the pre-hospital days recall how the laboring woman in her first stage preferred to be up around her house and seemed instinctively to keep walking about, halting only to lean over a chair while having a contraction.

2. We have heard women state very frequently that they wished they were able to move about in hospital during this first stage. We believe that this freedom would aid not only in diversion but in relaxation, and bring gravity to bear

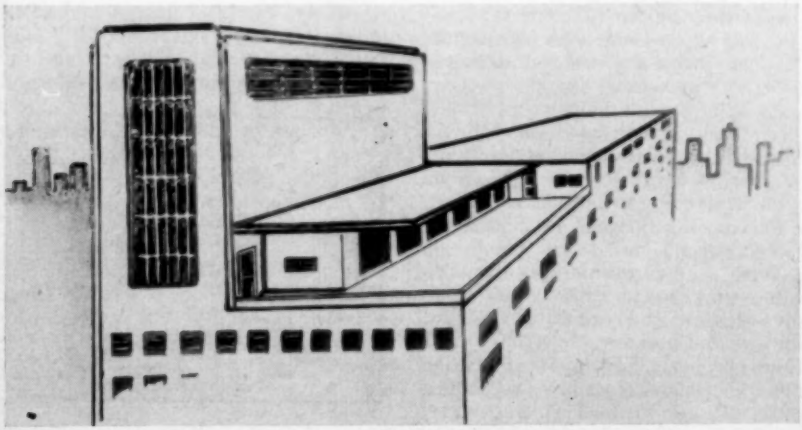

Fig. 4

on the laboring process. Our study of the situation of the fetal head by x-rays shows that it fits much more closely into the pelvic inlet when the woman is standing than when she is lying down. We believe that the better the head fits into the pelvis and lower uterine segment the greater the reflex stimulation to the contracting part of the uterus and the more efficient the contractions. When the woman is lying in bed, especially when she is lying on her side, the presenting part falls away from the pelvic inlet and it requires extra effort on the part of the uterus to push it against the inlet.

The Delivery Section is divided into two parts by a soundproof barrier and soundproof door as in *Fig 1*. To the right of this door are bedrooms which are also soundproofed. These rooms are for patients in the last part of the first stage and in the second stage up to time of delivery, when they are taken to case rooms. They can also be used by patients in the first stage who are tired and want to go to bed or for such patients who do require a sedative owing to an unusually drawn out first stage. The rest of the Delivery Section provides the usual case room facilities.

It seemed to me that such a plan would help greatly to meet the present situation as it affects labor itself in modern circumstances. But before going further with it I felt I should try it out on the women themselves. I, therefore, presented the idea to two different groups of women—one group consisting largely of older women and another (the Junior League) of young women, most of whom were actually either having a baby or between babies. They were so enthusiastic about the idea—it answered so many questions they had vaguely and even despairingly asked themselves during their labors—that I next proceeded to examine the Grace Maternity Hospital, Halifax, to see what could be done to integrate these ideas into the present building. It soon became apparent that this would be impossible without some new building. The Grace was built almost 30 years ago and has not been added to despite the fact that the city's population has doubled in that time. Its facilities are now being strained to the utmost and even to carry on its present work efficiently more space is required.

After consultation with university and hospital authorities, it was felt that in order to accomplish what we required, we would have to build a new floor or storey on top of one of the hospital wings. The hospital has been assured by their architect that this is feasible. In order to provide the space required it would be necessary to build an addition to the wing in question from the ground up—approximately 34 by 24 feet. This would provide a classroom for medical students and nurses—our own classroom has had to be used for patients—on the ground floor; a semi-private ward above this on the second floor and the additional space required for the floor plan previously described on the new third floor. The above plan has the endorsation of Dalhousie University and the Salvation Army, which runs the Grace Maternity Hospital.

In summing up, the following arguments in favor of such new building are presented:

1. The scheme proposed for handling the first stage of labor has never been architecturally integrated into any maternity hospital that I have heard of. It would be an example to other hospitals of a civilized and humane handling of women in labor. In the meantime, practising modern obstetrics in such a hospital set-up, we would be able to work out the kinks from such a scheme and so be able to proffer valuable advice to others intending to incorporate such an idea into their hospitals.

2. As the situation exists at the Grace Maternity Hospital, because we can build on top of a hospital wing already wired for electricity and piped for water, etc., this humane experiment in obstetrics can be carried out more cheaply than if an entirely new wing had to be built from the ground up.

3. As the Grace Maternity Hospital is the university teaching unit in obstetrics, the lessons learned in it would be spread through its graduate medical students to

other hospitals throughout the Maritime provinces and other parts of Canada and the United States.

It seems that the time has come for someone, somewhere, to provide, within a maternity hospital, those facilities required to meet, in the most humane manner possible, the needs of the modern woman having her baby.

Psychological Aspects of Mass Disaster

TRAVIS E. DANCEY, M.D.,C.M.

Average reading time — 16 min. 48 sec.

THE STORY OF MANKIND is dotted with periodic disasters, some of which have threatened the very existence of the species. These catastrophes have appeared without warning so that preparation for the onslaught could not be made. The great flood in biblical days, the Black Death, the Great Fire of London, and the cholera epidemic in the early 19th century are a few examples of mass disaster.

In addition to this unpredictable type of disaster, the existence of mankind has been repeatedly threatened by wars and their sequelae. The wars of the 20th century are much different from those which occurred prior to that time, both because of the types of weapons that are used and because of the fact that they have tended to become world-wide rather than localized to small areas. One must add to these facts the increasing significance of what is termed *psychological warfare*, by means of which the enemy attempts to affect the total population of the opposing country by creating fear as the forerunner of panic.

HOW PSYCHOLOGICAL WARFARE WORKS

The enemy attempts to make this state of demoralization a continuum. With this "softening up" process in existence, the civil population is vulnerable to almost any new and unknown military device. This state of affairs existed, to a certain degree, in England during World War II. It so happened that the Hitlerian propaganda machine was not able to send the V-weapons across the channel at the most favorable time. Had these weapons been available at the lowest point of morale, panic would undoubtedly have developed. When V-1 and V-2 bombs began to arrive, British morale was relatively high and the civil population of England, after an initial period of fear, was able to cope with the situation quite well.

It is a well known military fact that for every new weapon which is developed a more or less satisfactory counter-measure comes into being relatively soon. This truth can be applied to psychological warfare. During World War II, as rapidly as the enemy developed propaganda, our Psychological Warfare Division attempted to dispel the rumors. During a "cold war," although no guns may be fired, the psychological warfare continues so long as enmity exists between nations. There is no declaration of war and no armistice when this type of warfare is utilized. It carries on unremittingly and so insidiously that its existence may not be suspected by the very individuals whom it influences. Security regulations, by their very nature, assist the enemy since no story carries the same weight or affects the audience

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to the same degree as when it is prefaced by the statement that it is secret and must not be repeated.

A mass of rumor, subtly propagated and disseminated by the enemy, forms a necessary base upon which that same enemy may create panic reactions with relatively little effort. He utilizes the powerful psychological principle that fear is engendered to the greatest degree in situations where the threat is known to exist but cannot be coped with directly since the subject cannot come to grips with it. It might be compared to the state of affairs that would exist when a man is walking through a wood and has been told that something unfortunate will happen to him before he reaches a clearing on the other side. Every tree may hide his enemy.

It is difficult not to become panicky under such conditions. This principle is well known to be fundamentally important in the development of psychoneurotic illness, where threats to the subject's welfare have been present since birth but have been repressed and forgotten so that in adult life the individual is afraid though he does not know why. One might say that psychological warfare attempts to employ some of the devices which produce emotional illness in human beings. The symptoms of anxiety are identical with those which develop in a fear situation and the individual suffering from an anxiety neurosis, even under relatively ideal circumstances, has developed within himself so much fear that a relatively slight stimulus will produce overt symptomatology.

Combatting Propaganda

As a rule the best method for dispelling rumors and for dealing with the psychological warfare of the enemy is to maintain a constant flood of accurate information to the civil population. One might argue that in the face of a complete lack of defence preparations the public would quickly panic if told the truth. This does not appear to be the case and I would point to what occurred in England during the early phases of World War II. The English people knew that they had embarked upon a disarmament program, that sporting guns and pitch-forks might be the weapons of necessity. As a matter of fact they were told the truth in no uncertain terms by Winston Churchill with the result that instead of becoming powerless through fear they rallied and put forth tremendous effort.

In discussing this aspect of preparedness one meets the difficulty which surrounds what is known as security. Each country today has a number of closely guarded secrets concerning weapons and they hope that the enemy will not unearth this data. There is actually no point in acquainting the civil population with the majority of details about weapons. The security regulations permit the dissemination of a reasonable amount of basic information about the hazards of atomic warfare and this is of particular interest to us at the moment. Unfortunately, although we know a good deal about the relatively late effects of the atom bomb explosions at Hiroshima and Nagasaki, we do not know very much about what existed in the minds of the people.

During the past few years much discussion has taken place concerning methods which may be utilized to combat the morale-destroying effect of propaganda and to make sure that our civil population will respond with its maximum effort in the face of an emergency such as would exist in A.B.C. warfare. Since it is impossible to study this type of war directly, the Defence Research Board of Canada granted a fellowship to Dr. James Tyhurst of McGill University and for a period of two years each major disaster in Canada was studied fairly exhaustively in terms of its psychological effect on those in the danger situation.

People's Behavior

Dr. Tyhurst has contributed more to our understanding of the behavior of people in the presence of a disaster than has any other person. Therefore much of the material which I present will be taken directly from Tyhurst's

report.[1] He reports that there is a three-phase behavior pattern which may be broken down into: (1) a period of impact; (2) a period of recoil; (3) a post-traumatic period.

Period of Impact

The first period is that which occurs immediately upon receipt of the stress. This period lasts for a short time—from three to five minutes to one hour. Tyhurst found that in the maritime fire the impact period was present for three to six minutes; in the case of a flood, about one hour to one hour and a half. During this acute phase about 12 to 25 per cent of individuals are what might be described as "cool and collected." They behave in such a way as to indicate that they think clearly and evidently can formulate and implement a plan of action. The second group of individuals, during this initial phase, react as if "stunned and bewildered." They appear confused and show many of the physiological concomitants of fear and anxiety. This is by far the largest group making up about three-quarters of the survivors. The last group (10 to 25 per cent) show marked confusion, paralyzing anxiety, "hysterical" crying or screaming. This last group obviously may require psychiatric assistance.

Period of Recoil

During this period the majority of survivors are assessing what has happened to them and are seeking shelter. They are talking about their experiences for the first time. It is in this phase that the majority of individuals first show overt emotional expression concerning what has occurred. Women may show alternate periods of crying and laughing. At this time, and even somewhat later, the subjects of a disaster situation feel the need to express themselves verbally. Too often this is looked upon as inadvisable and relief workers attempt to keep these individuals from talking. The productions are full of criticisms aimed at any organization or persons who have been in authority and might in any way be held responsible even though this responsibility would be difficult to recognize at any other time. Even God is blamed for what has taken place. This finding of a scapegoat is a valuable means of relieving anxiety and tension. It has also had a good deal to do with producing more cohesion in the group of survivors. Therefore it is reasonable to suggest that survivors should be permitted to express themselves and should not be hushed up. In general the group of survivors itself will deal adequately with one of its members should he get out of hand in his expressions of criticism.

Post-Traumatic Period

This period is not at all dissimilar to that which occurs in the case of any soldier who was broken down in battle and has been evacuated. Depression, marked anxiety, repetitive nightmare, fatigue states, etc., are seen. Actually most psychiatrists believe that the first two phases, or in other words the fairly immediate reaction pictures, do not require any particular psychiatric intervention. It has been pointed out that the group of survivors itself will select leaders spontaneously from the above-mentioned 12 to 25 per cent of "cool and collected" persons. Descriptions of shipwreck and subsequent periods of time spent in life-boats, almost without exception, tell about some individuals who take charge and assume leadership upon their own authority and do an excellent job. The essentials of the personality characteristics of the "emergent leader" deserve further study.

Obviously the person who becomes unable to fend for himself during the immediate period following a catastrophe must be cared for. In spite of Tyhurst's suggestion that there may be a fairly large number of individuals in this group, there is other evidence which would indicate that it is not a very big problem. German observers report that during the heaviest air-raid on Freiburg (with a population of 100,000), during which 4,000 people were killed, only two psychiatric

casualties were brought to the University Psychiatric Clinic. During that time, the practising psychiatrists in Freiburg noted the absence of psychiatric casualties coming to their attention. It is difficult to imagine any greater mass disaster than that which occurred at Freiburg unless one contemplates the atom bomb possibility. It has also been pointed out that panic reactions were almost unknown in air-raid shelters.

During World War II, while the German guns from across the channel were shelling Dover, the population of that city showed no appreciable evidences of psychiatric break-down. It was only after these guns were silenced that quite a large proportion of the population began to show nervous symptoms. This points to what we can expect in the event of a mass disaster. The group will look after itself fairly well while the danger is present. One might say that in states of emergency the group becomes more important than the individual. It is only later that the individual begins to show nervous symptoms when he has the opportunity to consider what has happened and, in a conscious or unconscious way, to assess the possibilities of obtaining retribution or gain from some organized body such as the government, the Red Cross, etc. Sometimes the thought enters the subject's mind all too quickly, that unless he can show that he is suffering from definite symptoms he will not receive satisfactory compensation.

Evacuation

Should certain individuals be evacuated from a target area if sufficient warning is given to permit this to be carried out? That is to say, if we expect an atom bomb to be dropped upon Montreal, should a certain proportion of the population be evacuated to safe areas? Obviously this would apply to children. This evacuation should be carried out recognizing that more psychological damage sometimes occurred to children in England during World War II due to the evacuation than would have taken place had the children been left in the danger area. As a matter of fact it appears evident that children can withstand the stresses of a danger situation much more readily than the separation from home and parents. Bearing this in mind mothers or substitute mothers should be provided and the new home should approximate the old as nearly as possible.

Some writers suggest that old people should be evacuated. Obviously one could argue from two points of view about the advisability of this. I am of the opinion that any action here might be determined by the availability of time and of places to go. One writer recommends that any one who has had a psychiatric break-down should be evacuated. This, of course, is neither practical nor necessary.

Preparing Canada

In order to prepare ourselves for the possibility of atom warfare a registrar should be in existence with sufficient assistants so that one can determine the location of individuals. An information centre which will collect data about casualties without any delay should be set up. Plans for this should be made immediately since more panic is likely to occur due to worry about relatives, than concerning the danger to oneself.

The Canadian government has given the task of preparing the country for the possibility of A.B.C. warfare to the Department of National Health and Welfare. This department is working closely with provinces, cities, and towns to establish a complete organization which will provide the people of Canada with as much protection as possible.

In so far as publicity is concerned one must agree with Dr. Frank Fremont-Smith,[12] Consultant to the U.S. Air Force on Dynamics of Human Behavior, who recently offered Civil Defence officials three tips on how to reduce the threat of panic:

> 1. Explain to every citizen that even though A-bombs do fall in a given area his chances of survival are good. Instead of saying that two atomic bombs might cause "80,000 casualties" in a metro-

politan area like Los Angeles, say rather that casualties would be "not more than two out of every 100 persons in Los Angeles County."

2. Emphasize the idea of mutual aid. "If residents of a stricken city know that residents of all other cities are well prepared and anxious to help, all will feel more secure."

3. Make sure each person knows he has a job to do. "From experience abroad, we know that nothing does more to obviate threat of panic than a civilian defence set-up in which everyone, including children, is trained to perform a particular job. A small boy who knows it is his responsibility to have flashlights in good condition in his home seldom will panic."

Treatment Measures

Individuals experienced in the treatment of both civilian and military psychiatric casualties during World War II have already conferred under the auspices of the Department of National Health and Welfare. They are drawing up plans to cope with any emergency situation which may arise due to A.B.C. warfare. Certain principles must be borne in mind:

1. Psychiatric casualties should be retained at a treatment centre as close to the location where the break-down occurred as relative safety permits.

2. Treatment measures should be instituted at the earliest possible moment, disregarding hospital facilities as such and paying attention principally to physical comfort, such as warm dry clothes, etc.

3. Brief methods of treatment should be utilized and individuals must be urged to return to the group and to become a part of the group at the earliest possible moment.

4. For the patient's benefit the treatment centre staff should assume that nothing of a permanent nature has occurred and that the break-down is brief and unimportant in so far as his future is concerned.

Treatment methods may be listed as follows:

1. Free verbal expression will undoubtedly, in most instances, have already occurred and will continue for a time. It will, therefore, be necessary to supply workers who will listen. These individuals do not need to have any particular training in psychiatry, except to understand that they are not psychotherapists but are merely listeners.

2. A constant sorting of cases must be carried out by experienced psychiatrists in order to determine who should be discharged from the psychiatric treatment centre and who should be retained. These psychiatrists will also note those survivors who show evidences of organic (neurological) disorders as well as psychoses.

3. Brief psychotherapy, both of the individual and the group variety, should be used by experienced psychiatrists.

4. Obviously long-term cases should be evacuated to a greater distance for treatment. This should apply only to psychotics and near-psychotics; the others should not leave the proximity of the disaster.

5. Sedation both of the brief and prolonged type may be used. Narco-analysis with sodium amytal or sodium pentothal will be necessary.

6. Brief treatment with insulin sometimes is a useful procedure but, by and large, will be utilized at a more remote psychiatric centre.

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Milk Survey

In a survey, the Health League of Canada obtained the following estimates of the percentage of each province's milk supply which is pasteurized; Nova Scotia, 55-60 per cent of milk consumed; New Brunswick, 88 per cent of milk sold by licensed dealers; Quebec, 85 per cent of commercial milk; Ontario, 99 per cent of all milk sold; Manitoba, 65-70 per cent of milk consumed; Saskatchewan, 35 per cent of milk consumed; Alberta, 32 per cent of milk consumed; British Columbia, 85 per cent of milk consumed. No estimates were available from Newfoundland and Prince Edward Island.

A Departure from Tradition

M. Kathleen Ruane

Average reading time — 8 min. 24 sec.

During the past few years the shortage of nursing personnel has stimulated the development of schemes to provide high quality nursing service and, at the same time, to improve personnel practices in nursing. The years have also witnessed a change in the attitude of nurses toward institutions, agencies, and organizations which employ them. They are conscious of their due as employees and, although ready to accept their responsibility in caring for the sick and fully aware of the related unpredictable demands, they are skeptical as to how far they need be set apart from other members of the community who are gainfully employed. These nurses are thoughtful and sincere in their approach to nursing but there is a strong element of realism in this approach which is based on the belief that the economic and professional welfare of nurses directly conditions the quality of nursing service given.

Hospital personnel in general is seeking shorter working hours, a better arrangement of work schedules, some financial security against illness and old age through the implementation of pension plans, plus a salary, stated as a gross figure, that offers yearly increments. Because of the nature of nursing with its inherent responsibilities and the fact that until recently the hours of duty have been inordinately long, the most common request has been for better working schedules.

Hospitals have not accepted too readily changes in personnel policies. Tradition and customs with many years to their credit are rather firmly entrenched and they, together with the increasing deficit that burdens many institutions today, have militated against the introduction of improved personnel practices. Necessity has, fortunately, served to reconstruct the customary pattern of thinking to some extent and has demonstrated that nursing routines could be revised and re-distributed, resulting in a saving of professional nursing hours by assigning the less complicated tasks to appropriate personnel.

The director of nursing service finds it necessary to meet the needs of today by using to the best advantage the resources available, realizing the while that the quota of nurses for the future will not again reach the plentiful supply of a few years ago. She is likely to view these troublous times as blessings in disguise, rather than resign herself to an uncomfortable situation. She plans for the development of those features in the hospital scene which make for job satisfaction and lead to good personnel relationships.

When the subject of rearranging hours of work is presented for discussion it is frequently countered by such remarks as: "We cannot shorten hours or plan for straight eight-hour shifts. We haven't enough nurses." Or from the realm of administration, where balancing the budget is an important if almost impossible task in these days of rising prices, comes the cry of: "Increasing operating costs."

It is extremely unlikely that a sufficient number of nurses can be secured and maintained unless working conditions are made more attractive. So far as costs are concerned, it cannot be denied that there will be an increase in the payroll. However, if due consideration is given to the reallocation of duties to appropriate personnel, this increase should not be too staggering, while the benefits arising from a stable, enthusiastic, and experienced staff are of considerable worth though not so readily assessed in monetary terms. Another factor in economics which should be

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taken into account is that the incidence of illness in a staff not fatigued by long hours of work will, in all probability, be considerably less.

Any change in personnel practice presupposes the careful organization of detail on the part of those responsible for the direction of workers in the departments. At the same time we must bear in mind a line from Perry's "Puritanism and Democracy" in which he states that "gradualism is the one mode of reform that is consistent with democratic institutions." Conference discussions among head nurses, supervisors, and the director of nursing service on hour schedules, with a view to coordinating the service personnel with the work load, give impetus to the smooth operation of the plan to be adopted. An early calculation of the extra hours of nursing service it will be necessary to provide, when a shorter work week is instituted, will reveal the category and number of workers required. For example, "A Study of Nursing Service" published by the National League of Nursing Education, uses the norm of 5.5 hours as the number of hours of nursing service required per infant in 24 hours in a unit using professional and non-professional personnel. On an infant ward where the average patient census is 15, the number of hours of nursing service required in one week would be computed as:

15 x 5.5 x 7 — 577.5 hours.

The number of professional and non-professional workers on a 44-hour schedule, necessary to staff the unit for one week, is: 577.5 ÷ 44 = 13.1 or approximately 13. Where student nurses are members of the staff and adjustments are necessary for class time, additional nursing hours should be provided.

Perhaps our most radical departure from tradition has been to commence the hospital day at 8:00 a.m. instead of at 7:00 a.m. The change-over was readily accomplished and the advantages are so numerous and varied that one wonders why the reform has not been more generally accepted. In support of the theory that a nurse should live in a manner comparable to other young people in her social group and that a complete change of environment when off duty is desirable in the interests of her emotional and social well-being, more and more graduate nurses are encouraged to seek living accommodation away from the hospital. But much of the benefit of this move is offset if it is necessary for her to rise at the eerie and inconvenient hour of 5:30 a.m. as is the case if her home is far removed from the hospital. Patients have for many years voiced their protest against being awakened at an unusually early hour to have their faces washed and temperatures taken in readiness for breakfast that is served shortly after 7:00 a.m. They declare that they have only just gone to sleep when they are aroused for this early morning routine.

Prior to establishing 8:00 a.m. as the beginning of the day at the Children's Hospital, a conference was held which included representatives from the dietary department, the laundry, the laboratory, nursing service staff, teaching department, and administrative and medical staffs and anyone else who, it was thought, would be affected by a change in routines and time schedules. At the first presentation of the proposal the reception was cool. The idea was unfamiliar and required considerable mulling over before being accepted in preference to an old established custom. When the group met again a few weeks later the general attitude was one of enthusiasm and the representatives offered suggestions as to how his or her department could reorganize to fit comfortably into the total scheme. Experience would seem to justify the statement that the success of the venture is dependent on educating all the groups to the point where they themselves wish to share in its implementation and are convinced of its practicability.

The dietary department was pleased at the prospect of preparing and serving breakfast an hour later. The night nurses who had been working on 11:00 p.m.-7:00 a.m. shift now report on duty at 12:00 m.n. They

have discovered they do not have to leave in the middle of an evening engagement to report in on time. Practically every graduate nurse lives out of the nurses' residence and they have expressed a keen satisfaction in this new manner of living. In the operating room the first operation is usually scheduled for 8:30 a.m. but, if for some reason it is necessary to begin at an earlier hour, arrangements are made for an early breakfast for the operating room staff. In a large centre where a night staff is kept, adjusting to the later starting hour would not present a serious problem and could no doubt be solved by increasing the night staff sufficiently to enable them to prepare the rooms for necessary early operations.

We have found that it is easier to plan for straight shifts for all salaried nursing service personnel since the day has begun at 8:00 a.m. Practical nurses and ward aides work either 8:00 a.m. to 4:30 p.m. or 10:00 a.m. to 7:00 p.m. shifts. These hour schedules take care of the early morning work load and afternoon routines and at the same time provide for extra service when the student nurses leave the wards for morning clinics or afternoon classes.

Professional personnel has accepted, in the past, the traditional custom of broken shifts as a necessary hospital routine but the non-professional worker, a comparatively new member of the nursing team, has not taken too kindly to having her free time divided into portions in order to meet the service needs of the hospital. Where the broken shift is the custom it is necessary to provide not only locker rooms but rooms where the employee may rest and relax for the two or three hours of off-duty time at her disposal. Unfortunately, in a hospital where space is at a premium (and where is it not in these times of overcrowded departments?) rest rooms are inadequate or not provided at all. One might argue that the maintenance cost of rest rooms is an economic matter and, in the final analysis, might not the space be used to better advantage?

Starting the day at 8:00 a.m. was attempted over two years ago at the Children's Hospital and it has long since been promoted from the experimental stage to permanent status with the unqualified approval of all concerned.

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Physical Handicaps

Perhaps the greatest service which can be rendered to the physically handicapped child is to help him adapt himself to his disability, not in a spirit of passive resignation but of determination to overcome his sense of handicap and to fit himself for a useful and satisfying position in life. It is here that the services of trained educators, social workers, and experts in vocational guidance are essential. The education of the physically handicapped child should commence as early as possible, should be continuous, and should be undertaken by teachers who can approach and handle a child who is likely to be backward and distrustful of his own abilities.

Along with this education, it is of the greatest importance that the capabilities of the child for training and subsequent employment should be carefully tested and assessed by vocational guidance experts. Training colleges for the more severely crippled are often necessary but all young people capable of undertaking their training in the company of able-bodied youngsters should be encouraged to do so, as it always increases their sense of independence and self-reliance.

World Health Organization

Central Schools for Rural Areas

GERTRUDE M. HALL

Average reading time — 7 min. 36 sec.

ARE WE MOVING any closer to a solution of Canada's foremost and most complex problems—nursing now and for the future? This question was repeated in varying forms time and again as we journeyed across this vast Dominion during recent months.

Pointing to the experiments in nursing education already underway in Canada; stressing the need to await the results thereof before making hasty conclusions, did not always satisfy those who posed such queries. Turning then to other patterns which have been tried to a limited extent elsewhere, we sought to interpret and encourage the idea of central schools of nursing. Sporadic waves of interest in this pattern have arisen from time to time—just enough to encourage a few nursing leaders here and there to put down a few ideas, plans, and suggestions. The ideas are there all right but the need for financial assistance has, we believe, proved too much for those promoting plans for central schools of nursing. Only recently has there been any marked interest, on the part of those who control the purse-strings, in any proposals concerning nursing education where financial assistance is required.

Thus it has seemed that all the dreams and all the plans for any change or marked deviation from the present pattern were doomed before the ink had dried upon the paper. Some observers believe that what is needed now is a definite appeal on the part of one or more provinces for permission to use part of the federal grant allocated to research: this money to be used to set up an experiment for a central school of nursing.

WHAT IS A CENTRAL SCHOOL OF NURSING?

A "central school" has been defined as one whose administrative and educational personnel is organized so as to constitute an educational entity. The students' clinical experience is secured in more than one hospital and sometimes in other agencies as well. A central school may or may not be a collegiate school; it may or may not grant a degree; it may be initiated in situations where a school of nursing has not previously existed; or, by mutual consent, two or more schools may merge their resources, facilities, and personnel and each school lose its identity in the larger whole. Once established, such an institution would drop the word "central" from its name, the process being one of centralization and the result simply a school of nursing which offers the entire basic curriculum.

WHY CENTRALIZE?

If we accept the premise that the nurse of today must be prepared for the continuous evolution of modern health work—hospital and community—then we must also endeavor to provide a basic program which will include:

> Integrated teaching of all the sciences —biological and social; more types of clinical experience; better integration of the preclinical and clinical portions of the curriculum; permeation of the entire curriculum with the preventive as well as the curative, and the mental as well as the physical aspects of nursing; more emphasis upon the care of the ill in the home and in emergency situations; greater attention to the student's physical, emotional, intellectual, and social development; larger consideration of the function of the nurse as a citizen and as a member of the health services.

Is it reasonable to expect that all the present hospitals conducting schools of nursing in Canada, ranging as they do from 50 to 1,500 beds,

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should or could each develop a basic program of the type necessary to prepare nurses to meet the needs of modern society? It may be logically argued that many if not all the present schools have much to contribute. It is exactly for this reason that we believe so fervently in the idea of pooling all possible resources and utilizing them to the fullest extent. Many, if not all, of the present schools are operating, however, with limited, qualified teaching and supervisory personnel; there are never enough teachers of nursing. Some schools still lack laboratories, libraries, and other essential teaching facilities.

Cooperative Planning

Pooling resources and personnel may be the answer to some of these problems. This will, naturally, call for cooperative planning. One of the schools which has not admitted increased classes may have lecture rooms and laboratories that will accommodate some of the students in the enlarged classes of another school. If a college or a university is participating in the cooperative planning, its classrooms and laboratories may also be utilized. Public buildings of various types may likewise provide classroom accommodation for a group of schools. When schools get together for joint planning, even the least progressive school sometimes has something to contribute.

The fact that schools for which a cooperative plan is being made have different curricula and different admission standards introduces problems which may at first seem insurmountable. Group thinking, however, can usually find solutions to the various problems that arise. Cooperative planning should promote a realization on the part of the community of its responsibility for nursing education and the place of nursing in community health.

Suggested Procedure

May we now consider briefly the procedure which may be followed in setting up a central school, which has been very clearly set forth in Bulletin No. 4 published by the National League of Nursing Education and entitled "Nursing Education in Wartime." The major steps to be taken in cooperative planning are as follows:

1. Form a committee.
2. Formulate purpose of cooperative program.
3. Make a survey of potential facilities.
4. Draw up final plan and budget.
5. Procure necessary approval from cooperating institutions.
6. Recommend or select personnel.
7. Recruit students.
8. Set plan in operation.
9. Evaluate success of plan.

A very interesting experiment at present being developed in Britain is the establishment of group schools of nursing. A letter to the *Nursing Times* of June 2, 1951, written by Miss J. E. Clark, of Sheffield, gives the following vivid picture of the results, to date, of such group planning in nursing education in that country:

Group Schools of Nursing

I was interested to read the account of the Southampton Group School of Nursing published in your journal of May 5. Such schools are, indeed, an important trend in nursing education and will, no doubt, become more widespread throughout the country when the Area Nurse Training Committees begin their work. Having had experience in working in a hospital which participates in such a scheme of student nurse training, I should like to say that a good deal of readjustment has had to take place between the old method of individual training schools and the new method of joining large and small schools together and grouping them centrally apart from any of the hospitals.

Each student, on making application for training, is allowed to choose in which hospital she wishes to take the greater part of her training. It then becomes her parent hospital and she is not permitted to change. She joins the group Preliminary Training School and later the blocks held in the school, returning afterwards to work in her parent hospital. The question of a nurse's loyalty has presented

quite a few problems and many wonder whether they belong to the group school or to their parent hospital. Inter-hospital contacts help to ensure healthy competition and rivalry but can only be of use if each and every nurse feels that she can put down roots and know that her own individual effort is needed in the group.

The main factor is that there must be complete cooperation between the matrons, tutors, and ward and departmental sisters. Personal differences must be overcome and the nurses' training a matter of prime importance. Here I would say that the proper care of the patient and, therefore, the proper staffing of the hospital is also of great importance and while we are unable to consider the student nurse as a supernumerary and have to count her as a member of the staff, these two important factors must be considered side by side. Matrons and tutors together are responsible for seeing that each nurse is properly trained and prepared for the examinations, while matrons have the dual responsibility of the nurses' practical training under adequate supervision in the hospital and of providing proper nursing care for the patients. Hence the need for appreciating each others problems and discussing them without prejudice.

Ward sisters must know the methods of practical work taught in the classroom and sister tutors should be welcomed in the wards and know that what the nurses have learned in the classroom will be carried out there. Meetings to discuss practical procedures or other problems connected with nurse training, common to all the hospitals, seem to be a satisfactory way of achieving uniformity. Hospital grouping and central schools are part of the plan for improving nursing education within the National Health Service. Let us, therefore, set out on this venture with high ideals and enthusiasm, laying aside personal prejudice and ambition.

In summing up, the general objectives underlying the establishment of central schools of nursing might be stated as follows:

1. To give the student a better than ordinary understanding of community needs and nursing care.
2. To produce nurses interested in small groups, small hospitals, and rural community work.
3. To prepare nurses, conscious of the fact that hospital experience is but one part of the patient's experience during his illness.
4. To develop in the student the awareness that nursing care in hospital is only one part of health conservation and cure of disease.
5. To place a greater emphasis on basic sciences, both biological and social, than is possible in the ordinary hospital school.
6. To give a community emphasis for a non-urban region.
7. To produce, through their educational experience, a type of nurse more useful in our modern society.

Funds have been provided from the Federal Health Grant for planigraphic x-ray equipment for the Vancouver unit of British Columbia's Tuberculosis Control Division. The new apparatus will be able to handle the increasingly large number of x-rays required and generally will improve the service given by this unit.

The availability of insecticides has been sharply affected by the shortage of essential raw materials (chlorine, benzene, and sulphuric acid) resulting from defence programs of the major producing countries. Survey showed that a total of 23,688,000 pounds of DDT will be needed for the last half of 1951 and the full year of 1952.

The most serious effect of any major interruption of DDT supplies to countries conducting malaria-control programs will be to expose the populations recently protected to "serious risk of malaria epidemics" because the people will have lost the degree of immunity which they had previously developed when malaria was always present.

Production of insecticides in the United States is "increasing in spite of the many difficulties in regard to raw material supplies, transport, and the provision of containers." However, the availability of supplies for export "is most uncertain," partly because of the variation in internal demand.

— *Pan American Sanitary Bureau*

Taking the Hospital Home

WILMA A. HOWES, B.A.

Average reading time — 5 min. 36 sec.

A CONSIDERABLE amount of interest has been shown lately in the new plan of home care for hospital patients, which is now in effect at the Herbert Reddy Memorial Hospital, Montreal. Just how does it work? That was the question we asked ourselves when it was decided to develop this plan at our hospital as the first such arrangement in Canada. Before inaugurating the department, much investigation was done of the plan in New York City which had been in operation for several years. With the information gathered it was decided that the interne staff required to be increased by only one. The Victorian Order of Nurses agreed to supply nursing care in cooperation with the hospital. While the New York plan gave home care to only specified groups, we decided to include all cases from a general hospital.

A graduate nurse is the supervising secretary, being advised on legal or medical problems by the president or the medical superintendent. The patient in hospital is referred to her by the staff as a possible transfer to home care. Then she arranges with the doctor for the number of times he would like to have the interne and the V.O.N. representative make visits. This demands a close cooperative effort between departments with the overall aim of restoring the patient to health and, at the same time, giving the hospital more available beds for admissions. The fact that it is much more economical to the patient and that he is in his home environment, which is more conducive to recovery, seems to hasten the process in an amazing fashion.

It has been interesting to watch the number of little red signals increase on the large wall map of the city of Montreal, each indicating another patient at home.

Any new venture in the medical or nursing world seems to be treated with great caution at first and this new home care plan is a shining example. Being interested in this plan as a teacher of student nurses, I felt I should see the patient in his home environment to be able to speak of its advantages. If she has this knowledge the student can discuss the plan with the patient during her many daily services at the bedside. There are so many occasions when the patient speaks longingly of home, wondering if he will ever be back there. The nurse could more readily give reassurance.

One afternoon I went along with the interne on his home calls. Having always done institutional nursing I found it most interesting to see the living conditions of patients I had known in the hospital. One cannot really know or understand fully the problems which confront the patient until one sees the environment from which he comes. Often it explains so much of the "why" of the illness and helps in the planning for the recovery and convalescence.

Our first call was to Mr. A., a man in his late fifties, who had had a severe heart attack. He had been on the dangerously ill list for several days while in hospital but had responded sufficiently to therapy to be considered fit for home care. He lived in a tiny room off the kitchen in a very small, cramped apartment. He was being cared for by a very anemic-looking married daughter, who had numerous squabbling children racing about. This was definitely not the quiet environment, with bed rest and excitement at a minimum, that is desirable for cardiac patients. Nevertheless, he was improving and was very happy to be home. After a brief

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In her capacity as instructor at the Herbert Reddy Memorial Hospital, Miss Howes has played an important part in making the home care plan work.

check by the interne, we were putting on our coats, then into the taxi and on our way to the next call.

On the drive over, the interne gave me a brief résumé of what I would be seeing and hearing. Here was a very different situation—a comfortably furnished upper duplex where lived a very ill old lady suffering from diabetes as well as a heart condition. Her two daughters attending her seemed to ignore the seriousness of her illness. The patient was lying back against her pillows in an apparently semi-comatose state. She barely responded to the interne's voice and all the daughter could repeat was, "Can't Mama have a hypo so she can get some rest?" She seemed quite unaware of the serious state of her mother's health, which was partially due to the daughter making substitutions in the special diabetic diet. It was evident this patient must be returned to hospital to be investigated and reorganized in her diabetic régime. We left, feeling that the daughter lacked the proper insight to be responsible for her mother's care.

From there we had a long drive out to Ville Emard to see a convalescing patient—one who had had pneumonia and a recurring peptic ulcer. Orderliness, cheerfulness, and cleanliness met us from the moment we stepped inside. The bed was near the window, flowers, and cards were all around and the patient, looking quite cheerful, was listening to the radio. She was so pleased when the interne, after a routine check of her chest, said he believed her sufficiently improved that she could be discharged from home care. She could get up and around gradually and was to come to the out-patient department soon for another check up. This was wonderful news to her and she promised to be careful. In a few minutes we were on our way again.

We made two more visits that afternoon. It was gratifying to see how much happier the patients seemed to be in their own environment, with relatives caring for them. The V.O.N. had preceded us on our calls by an hour or so, giving the necessary nursing care and leaving the chart of observations and treatments to date.

The interne and the V.O.N. act under the instructions of the patient's own doctor, so the patient is in effect receiving hospital care in his own home. In this way the home care plan is advantageous to both the patient and the hospital. The patient receives the equivalent of good hospital care at much less cost. The hospital facilities are left free for urgent cases. So, by helping themselves, patients coming under the benefits of the home care plan will be helping others.

I found the afternoon most profitable and certainly feel that now I shall be able to speak of the home care plan in a more intelligent manner.

Enuresis

Enuresis is not a disease in itself but is nearly always a symptom of a psychologic disturbance. Treatment consists largely in re-educating the parents and the child. The following rather different suggestions have been found helpful:

1. Do not talk about bed wetting at any time in the child's presence.
2. Do not waken the child at night.
3. Do not change the bed linens or pyjamas, except when making the routine changes of linens for the rest of the family. This may be once or twice weekly. Dry the wet linens and clothes and replace them. The child will tire of the smelly odors and rough clothes when he discovers that he is the only one suffering. This is an incentive to keep dry.
4. Limit the 24-hour intake of all fluids.
5. Medication is of questionable value.

— Norman W. Clein, M.D.

Cupboard doors and bureau drawers will slide easily and not stick or jamb if you rub the edges with paraffin wax or dry soap.

Lyle Creelman *Writes . . .*

Average reading time — 7 min. 36 sec.

BACK IN GENEVA again after nearly three months' absence. And what a packed three months it has been—starting with a visit to Regional Headquarters in Washington, New York, Montreal for the meeting of the C.P.H.A., Toronto, and then six weeks at home in Vancouver. It was hard to leave because never has Vancouver looked more lovely. I never will be able to convince my friends here that roses could possibly grow so large! But the day came when I had to say "au revoir." Between planes at Seattle I managed a brief visit to the school of nursing of the University of Washington. Incidentally, this proved a most profitable one for WHO because I discovered that Kathleen Leahy, associate professor of public health nursing, is to be on sabbatical leave this coming university year. I practically signed her on, then and there, to come to Geneva and work with us at H.Q. in preparation for a Working Conference on Nursing Education which we hope to convene next April. (This turned out to be possible and she is coming in October. Miracles sometimes do happen!)

My next stop was at Guatemala City where I spent six days at a Workshop on Administration, Teaching, and Supervision in Nursing which was sponsored by the Pan American Sanitary Bureau. Some 20 nurses from nine Central American and nearby countries worked and studied together for six weeks. The staff included Dr. Verna White of Syracuse University as educational director, Elfleda Sprague, nursing consultant, P.A.S.B., and others from North and South America. The languages used were English and Spanish and it was interesting to note that the majority of the participants did their own translating. The first two weeks were spent in defining their problems. Then these problems were studied by the group as a whole or by small groups. Opportunity for individual conferences with the staff was available throughout the whole period thus providing the possibility for discussion of specific problems with experienced nurses in the various fields. The workshop method is proving to be a most valuable means of giving more nurses the opportunity of learning how to solve their own problems than could possibly be done through lengthier and more costly fellowships.

I wish time and space permitted to tell you about the fascinating country of Guatemala. The climate is delightful and, having just come from the drought of the West Coast where lawns were parched and brown, the deep green of the countryside was surprising. More than half the population of over two millions are Mayan Indian. The Mayan culture is very rich and today the native Indians produce beautiful weaving and other hand-made articles. Guatemala is surely a tourist's mecca and for those who can travel this far afield a holiday there will not be a disappointment.

I can only mention the interesting nutrition experiments being conducted in Guatemala and other Central American countries by INCAP under the direction of Dr. Scrimshaw. Surprising facts in relation to the kinds of foods, which can be substituted for animal proteins in countries where there is an almost non-existent supply of meat and milk, may soon be available.

From Guatemala City I flew to San José, the capital of Costa Rica. En route we touched down at Tegucigalpa (Togoose for those of us who can't get our tongue around the real thing), the capital of Honduras, and Managua, the capital of Nicaragua. The artistic and airy construction of their airport buildings would put many of ours to shame. Incidentally, if any of you dislike "bumpy" flying

you should find some other means of transport when you visit Central America.

In San José, WHO is assisting the school of nursing of San Juan de Dios Hospital in the reorganization of the nursing program. This is a very large hospital, over 1,300 beds, serving a large community. It is very overcrowded—many of the beds have two patients. I actually saw two mothers and two babies in one bed and a mother coming back from delivery being put into the same bed with another post-partum case. In the tuberculosis ward also many beds held two patients. The medical and nursing leaders are most anxious to improve the school in order to prepare more nurses better qualified to meet the urgent demands for nursing care. We have a team of four, the leader of which is Fernanda Alves Diniz, from Portugal, who studied in Toronto and who is on leave of absence from her position as director of the School of Nursing in Lisbon. When I saw her in Costa Rica with the hospital authorities she was making a selection of wards for the clinical practice of the students and also spotting available space in each—perhaps just a corner of a corridor which could be partitioned off—for a ward teaching room. How many Canadian schools of nursing have this fine feature for teaching?

Then I travelled back to San Salvador, arriving right at the beginning of the annual August holiday. I don't know who invented firecrackers but I am quite sure the idea was never to start setting them off at 4:30 in the morning. I didn't get much sleep there but who would want to stay in bed when the markets, where one could buy for a song the most luscious of tropical fruits, opened at 6:00 a.m.? I bought a dozen bananas for about 25 cents and a big pineapple for even less.

In El Salvador I visited a Tuberculosis Demonstration Project which has been in operation for over a year and where local personnel are being trained in diagnosis, laboratory techniques, treatment, and follow-up. Here also WHO's first Health Demonstration Area is being started. The area almost surrounds the volcano of San Salvador which has not been active since 1937 but, as a result of its activity then, there is an extensive area of potentially fertile land covered with black lava. When at H.Q. we had read in a report that some people actually lived in the crater of the volcano we were a little sceptical of the veracity of the statement. I had a side trip to the top and looked down into the huge bowl where there were visible two or three little huts and a field of corn, indicating habitation. In San Salvador I met Mr. George Melrose, Deputy Minister of Lands for British Columbia, who is heading a U.N. mission there. He joined our party when we travelled over the roads of the Demonstration Area; roads over which only an ox-cart or a jeep could navigate. We went through many little villages, all with their colorful markets, and stopped to see the facilities for the Headquarters in Quezaltpeque. The interest of the people in the Demonstration is remarkable. Since a building for the centre was not readily available the mayor volunteered to vacate his unusually spacious house so that it could be used until a Health Centre can be built. The team who will be responsible for the launching of this project will have many problems, the greatest of which will probably be the lack of nursing and sanitary personnel. Nursing in El Salvador has not a high status and few girls who go beyond primary school enter nursing. It will be necessary for some time to use auxiliary personnel trained on the job. Another time I will tell you more about the Health Demonstration projects. Others are planned for Egypt and Ceylon.

The visit in Central America came to an end all too quickly. After a day in New York I left by the comfortable B.O.A.C. *Stratacruiser* for London and Geneva. When I started out on my home leave I intended to keep a record of my first impressions in Canada after an absence of two years in Europe where the way of life is so

different. I didn't do this but two observations stand out most clearly; the high standard of living enjoyed by most Canadians and Canada's need for more people. As I flew over Nova Scotia the forests and fertile valleys were clearly visible below. Apart from the few towns and cities I could see houses only here and there—and the same is true for most of the country from east to west. A few hours previously I had flown over France—the contrast was startling! Even at the risk of lowering our standard of living, which we inevitably must do if our population is increased to that which Canada can support, we must open our doors to the people from countries which are so crowded and over-populated.

Institute on Ward Administration and Supervision

Some months ago, Miss K. Feisel, director of nursing, McKellar General Hospital, Fort William, wrote to Miss Katharine Densford, director of the School of Nursing, University of Minnesota, for assistance in arranging an institute for the supervisors of the McKellar hospital. Miss Densford very kindly co-operated by asking Miss Florence Brennan, a member of the staff of the University of Minnesota, to come to the Lakehead for two days. Miss Brennan sent an outline of the topics selected and a reading list prior to her visit and the supervisors spent several evenings together preparing for the conference.

On June 14 and 15, more than 20 supervisors and head nurses participated in the institute which was held in the nurses' residence at McKellar General Hospital. The topics dealt with were as follows:

The head nurse and supervisor in the modern hospital and school of nursing.

Scientific principles of administration as related to a good nursing service.

Personnel of the head nurse unit.

The qualifications and preparation of the head nurse and supervisor.

Two interesting films were shown which served to bring out important points of the conference. The film "Strange Interview," which is produced and distributed by General Motors, showed exceptionally well the effect of a negative personality on human relations and positive supervisory methods. The film on the "Nursing Care of Cardiac Failure," which may be obtained through the United States Public Health Service, showed what is meant by "total" nursing care.

Throughout, Miss Brennan presented the subject matter in a detailed and comprehensive way and general statements were elucidated by reference to actual ward situations. There were many helpful suggestions for the supervisor as she functions as a leader. The following "Don'ts for a Supervisor" will illustrate how Miss Brennan made her subject meaningful and interesting:

Don't be a hummingbird.
Don't be a detective.
Don't be a nettle.
Don't be a fly-wheel.
Don't be a grouch.
Don't be a sphinx.
Don't be a fish-wife.
Don't be a machine.

Throughout, friendly relationships permeated the institute, even though so much had to be covered in a short period of time. Coffee was served each morning before the conference began and, on the afternoon of the first day, tea was served on the lawn of the Patterson Residence. At the conclusion of the institute those attending and other guests were invited to a buffet supper which was prepared by Mrs. Teeple, the dining-room supervisor for the McKellar staff. Each person will remember for a long time the beautiful floral and fruit arrangement of the table.

Although the hospital sponsored the institute, the supervisors wished to show their appreciation to Miss Brennan in a more personal way. So, on behalf of the group, Miss Jane Hogarth presented her with two fine English cups and saucers.

Since the conclusion of the institute interest has carried over to the general staff nurses' group who did not have an opportunity to attend. They are now asking when they are going to hear the details of the course at staff meetings.

The two-day institute held in Fort William will not soon be forgotten for in the vivid presentation of the material each supervisor had an opportunity to observe and appraise herself as a supervisor in relation to the modern meaning of supervision.

— Dorothy G. Riddell

Nursing Profiles

Elva C. M. Honey, A.R.R.C., has been appointed the director of the School for Graduate Nurses of McGill University, Montreal. She has been acting director for the past several months.

Born and educated at Binscarth, Man., Miss Honey enrolled in the pre-medical course at the University of Manitoba on the completion of high school. A medical degree was not to be her's, however. Instead, she entered the school of nursing of the Winnipeg General Hospital in 1931. Receiving a scholarship following her senior year's work, Miss Honey secured post-graduate training in obstetrics and gynecology at the Royal Victoria Montreal Maternity Hospital in 1935 and returned to W.G.H. as nurse-in-charge of the gynecological department.

The outbreak of World War II in 1939 and the resultant demand for nursing sisters evoked a ready response in Miss Honey. She enlisted in December of that year, proceeding overseas as assistant matron of No. 5 C.G.H. the following June. As matron of No. 5 and later of No. 14 she saw active service in England, Sicily, and Italy. She was awarded the associate medal of the Royal Red Cross in 1943.

Returning to Canada in 1945, Miss Honey registered with the McGill School for Graduate Nurses where she received her bachelor of nursing degree, specializing in administration in schools of nursing. In 1947 she was appointed an assistant to the director of nursing at the Montreal General Hospital. Two years later she was named as the nursing consultant with the Department of Veterans' Affairs in the Montreal area, responsible for the coordination of the nursing service and staff education programs of the various D.V.A. hospitals in that area.

Keenly interested in administration with an alert mind and a vital personality, Miss Honey will continue to build the School for Graduate Nurses on the solid foundations laid by her predecessors.

Dorothy Jean Stevenson is the nursing superintendent of the War Memorial Children's Hospital in London, Ont. Miss Stevenson has been greatly interested in work with children ever since her graduation from Toronto Western Hospital in 1938. She served for a time as head nurse on a medical ward at her own school, then specialized in pediatrics with a course at Children's Memorial Hospital, Montreal. She was supervisor of the girls' ward at the Montreal Shriners' Hospital for a year then went to the Hospital for Sick Children, Toronto, as a supervisor. To round

Garcia Studio, Montreal

ELVA HONEY

DOROTHY J. STEVENSON

out her experience, Miss Stevenson secured her certificate in public health nursing from the University of Toronto School of Nursing and joined the staff of the Simcoe County health unit, Barrie, Ont., in 1948.

Major Margaret Crosbie has been appointed superintendent of Grace Hospital, Vancouver. A graduate of Grace Hospital, Windsor, Ont., Major Crosbie has been an officer with the Salvation Army for 21 years. During that time she has been office manager at Montreal's Catherine Booth Hospital, director of the nursing school at the Bloor St. Hospital, Toronto, and recently assistant superintendent of Winnipeg's Grace Hospital. She succeeds Major Gladys Gage who has been transferred to Winnipeg.

MARION LINDEBURGH, O.B.E.

Marion Lindeburgh has retired from the directorship of the McGill University School for Graduate Nurses after more than 20 years of faithful, devoted service.

The tribute paid to her recently by the president of the School Alumnae Association in their *Newsletter* is worthy of repetition in these columns:

> It was with real regret that we learned of Miss Lindeburgh's illness in the late summer (1950) and of her impending resignation from the School, effective at the end of August this year. The School for Graduate Nurses, McGill University, and Miss Lindeburgh have become synonymous to most of us and we were filled with dismay at the prospect of having to alter our thinking.
>
> From her earliest association with the School, Miss Lindeburgh has been at the service of the students and graduates, giving far more freely of her time, experience, and understanding than we had any right to ask. Yet it is this generosity that has made her so much a part of each of us and which causes us to think of her always as "our Miss Lindeburgh."
>
> The busy university life did not deter her from giving of her time to other professional groups, which she served with the same reckless expenditure of energy. It has always given us great pleasure to hear of the awards that have come to her, and with each we have said "she deserves it." The O.B.E., the Mary Agnes Snively Medal, and the honorary degree of Doctor of Science are but public recognition of her services to nursing and nurses; from her former students she will always have love, gratitude, respect, and warm good wishes for her future happiness.

A full account of the outstanding imprint "our Miss Lindeburgh" has made on nursing in Canada was published on page 388 in the May, 1950, issue of *The Canadian Nurse*. Though she has severed her connection with the School, as her health improves she hopes to continue to make noteworthy contributions to her beloved profession. The good wishes of all Canadian nurses are extended to her!

New Brace Invented

Congenital dislocation of the hip in children has been greatly benefitted by the invention of a brace by Dr. Gerald Burk of Vancouver. The brace consists of a padded metal abdomen and back-plate with crossbars to secure the thigh, yet allow the little patient complete freedom of movement, even to walking. Necessity for a heavy cast is obviated but early application of the brace completely corrects the deformity without the necessity for operation. Children are reported to be walking quite satisfactorily at the normal time instead of at four or five years.

— *Ontario Medical Review*

Public Health Nursing

Home Visiting

MARGARET OULIMAR

Average reading time — 7 min. 48 sec.

"LET'S GO AND visit the Wilsons." So, with no better reason than that we want to go, and no more preparation than powdering our noses and putting on our hats, we go visiting. We are sure we will be welcome because they are our friends.

When the nurse from a health agency, such as the Victorian Order of Nurses, goes visiting it is more than a social call. The reasons for going are more important. The preparation requires time and planning. However, there is one similarity and that is in the welcome she will receive. Now, armed with a good reason, well prepared, and sure of a welcome, the nurse starts on her way.

To have a purpose for the home visit is as essential in nursing as it is in living a healthy normal life. It becomes a goal to strive for, a guiding purpose by which we measure what we are, what we do, and what we achieve. What, then, is the purpose in home visiting? It falls under three main headings: (1) To promote and maintain health. (2) To prevent and control disease. (3) To care for and rehabilitate the sick.

When all three are kept in mind it leads to the overall purpose of public health nursing. This is to assist the family, the smallest unit of democracy, to attain and maintain self-dependence through healthful living.

The nurse is able to teach health by means of the home visit with good results because the family is seen as an entity. We cease to consider any one member apart from his family and community relationships. The family is in familiar surroundings and, consequently, more at ease because of their "at homeness." Then we are able to evaluate the need more accurately, and in a shorter time, because we are aware of all the environmental factors which contribute to the health and welfare of the patient.

In every home visit, made by a nurse for any reason, there is an opportunity to teach health. However, the teaching, in order to be effective, must be planned. When it is planned to bear a proper relationship to the visits that have gone before, and to the ones that are to follow, the lasting effects are greater and both the teacher (nurse) and learners (the family) gain greater satisfaction through the process. "Sequence in presentation is an important law of teaching." (Gardner) The nurse will also be capable of establishing a friendly relationship. The best foundation for this is a sincere interest in the family.

Finally, the nurse must have something to give. There is no substitute for genuine knowledge and the family learns to accept her as the expert in public health nursing. "She will achieve success in direct ratio to what she puts into her visits, and what she is herself." (Gardner) The knowledge she imparts as a part of her guidance program with the family must be timely and bear a relation to the family needs at that time. Every family she visits has its own pattern. The same principles of health will be adapted to each home according to

Mrs. Oulimar is senior nurse in the West District of the Montreal Branch of the Victorian Order of Nurses.

the needs as seen by the intelligent nurse. She must have scientific knowledge plus a "feeling for" the individual situation. This is empathy, a process which each public health nurse uses to establish her welcome (good rapport) in thousands of homes in Canada each day and which assists her to apply her scientific knowledge effectively.

The opportunity of seeing the family as a whole, and in its familiar surroundings, gives us a distinct advantage for effective teaching. For example, teaching the prenatal patient the importance of a daily rest period seems, on the surface, simple enough. However, one home visit reveals that this woman has four children of various ages and a husband who must sleep most of the day because he works the "graveyard" shift. She lives in two rooms in a congested housing development. This simple need, a daily rest, is an impossibility. The home visit makes us aware that simply telling the mother is not enough. The nurse must know the factors that will affect this teaching. This awareness results in better understanding and more vital teaching.

We now come to the second reason for visiting—the prevention and control of disease. To use a diabetic patient as an example—our visits to the home enable us to know where to start teaching. The nurse must begin where she finds the patient—at the level of his understanding. She may discover that she has to start at the very bottom—personal cleanliness and adequate nutrition. She may find she can begin at the more advanced stage of 5 per cent and 10 per cent vegetables, substitutions, or the necessity for particular care of the skin to prevent injuries and the reason for this. The patient may be able to give himself his insulin skilfully but may resent the fact that he has diabetes. We can help him learn to live with his problems and become a useful, happy, healthy member of his family and his community.

In considering our last reason for visiting—the care and rehabilitation of the sick—we must accept the responsibility of seeing that it is provided. There are many cases of illness in the home where skilled nursing care is not required full-time. By teaching some nursing procedures, such as giving insulin or care of colostomies, we enable the patient and his family to become more self-sufficient. This is important from the standpoint of mental health as it assists in building the self-dependence of the family as a unit. In the case of a long-term illness, such as hemiplegia, arthritis, or cancer, the nurse teaches the family how to care for the patient at home. Nutrition, care of the skin, the importance of good bed positions, and a happy atmosphere are essential.

The adjustment of the family to illness is important because whether the illness is temporary, or promises to be long-term, a certain amount of adjustment is necessary. The problems are many—finance, housekeeping, continued costly treatments, physiotherapy, occupational therapy, and perhaps part-time work. It is in this instance that the knowledge of the community resources is invaluable. We are not working alone. We are one member of the health team. Our ability to recognize the need for outside help allows us to place the problem with the people who are most competent to deal with it.

Rehabilitation is a very important word and it must not be used glibly. We must consider our responsibilities and our opportunities in this increasingly important field. Doctors, nurses, institutional staffs, and social workers are aware of the necessity for a continuous, integrated service to the patient. We shall find a daily increase of demands on us to provide this service. Our responsibility to the veterans has pointed up the possibilities in a well-planned rehabilitation program and we must be prepared to offer it to all patients. In order to be most successful, the program should start at the time of diagnosis and be continued in the home.

We have considered the three reasons for home visiting and now the preparation. Our preparation goes back and includes all we have learned

about nursing, about health, about disease, about teaching, and about skilful interviewing. Add to this a genuine interest in people and a sincere desire to help. This nurse is not just prepared for one visit but for all visits. Our preparation for a specific visit is to secure all available information and have a flexible plan that may be adjusted to individual needs in guiding the family to self-help.

And now we return to compare the social visit with the Wilsons and the visit of the public health nurse in Canadian homes. The Wilsons welcome you as one who has been there before and must have enriched those visited. The public health nurse enriches the homes when her visit has been effective. How do we know if it is? For many years now, nurses have been carrying the messages to the homes of the nation on an increasing scale. Over the years the health of our nation has been improved. The variety of these visits is shown in a chart on page 77 of the Baillie-Creelman Report of the Study Committee on Public Health Practice in Canada. The home visit is the corner-stone of public health. It is an art developed by qualified nurses who have knowledge of public health plus respect for the integrity and personal worth of every individual. These nurses cherish this little democracy—the family. They have developed empathy, a feeling into the situation—the family circle—and deem it a privilege to be invited to enter.

Because public health nursing is an essential service to our Canadian homes, and because the efficiency of living has been improved in each home through this service, there is a greater demand for more qualified public health nurses than can be supplied. The need must be met. One method is to have each nurse, working alone or on a staff, critically appraise her program and pool her findings with others in her field to see how she can meet more effectively the health needs of Canada. It is an exciting challenge. The public health nurse is the expert in her field who should assume leadership to meet this challenge. Let's do it!

Children's Needs

It is generally recognized that the earlier a persistent behavior disturbance occurs, the greater the likelihood of its lasting effect on the personality. In the first six years of life are laid the foundations upon which the structure of adult personality is built. Mothers have, in the past, been much influenced by the teaching of child health workers in such matters as nutrition and cleanliness. With the new knowledge at their disposal, these workers can also influence the upbringing of young children in the direction of healthy psychological development. They can do this both by discouraging practices and attitudes which are known to damage or handicap the personality as it develops and also by encouraging those which fill the growing child's needs. It has been realized that some child care practices, based solely on protection against infection and malnutrition, were actually damaging from a psychological point of view, creating stress and anxiety in the child with lasting adverse effects.

In the economically advanced countries, therefore, one finds child health services now setting out to restore the balance by encouraging parental care which gives equal weight to the physical and mental needs of the child. In countries which are still in the process of creating their child health services, the problem is different, since from the start it will be possible to give balanced consideration to these needs. While this task is immense, those countries have the opportunity of profiting by the experience and the mistakes which resulted from the lack of psychological knowledge which existed at the time when earlier child health services were being developed.

World Health Organization

Institutional Nursing

The Story of Anesthesia

G. H. Stobie, M.D., F.R.C.S., F.A.C.S.

Average reading time — 5 min. 12 sec.

(*Concluded from September issue*)

Simpson's paper, "Answers to the Religious Objection Against the Employment of Anesthetic Agents in Midwifery and Surgery," published in 1847, is a masterpiece of its kind. He first presented the justice of his own stand by analogies in other occupations and used in support quotations from Genesis. He argued that if literal translation is adhered to, the farmer, in pulling up "the thorn and the thistle" which the earth is doomed to bear, and in avoiding shedding "the sweat of his face" in tilling the ground through the use of horses and agricultural machinery, is also going against the express command of Scripture. If literal translation is strictly adhered to, he argued, the physician would also be wrong in trying to save human life, for it was ordained that man should be subject to death—"Dust thou art, and shalt to dust return."

If it was justifiable for the agriculturist to try to counteract the effects of one part of the curse and justifiable for the physician to try to counteract another part, then surely it was justifiable for the obstetrician to counteract the effects of a third part of it.

> Are those who maintain the uncanonical character of using human means to contravene the pains of childbirth, ready, then, to maintain that we shall not use human means to contravene the tendency to death, or to increase the fertility and produce of the ground, except by personal labor, and the actual sweat of the brow?

He went on to show that opposition, particularly on theological grounds, had been presented against every humane innovation in the past. For instance, the opposition to the introduction of vaccination against smallpox:

> Smallpox is a visitation from God, and originates in man; but the cowpox (vaccination) is produced by presumptuous, impious man; the former, Heaven ordained; the latter is a daring and profane violation of our holy religion.

A more practical opponent told of the effects of this "profane violation" in the case of "a lady who complained that, since her daughter was vaccinated, she coughs like a cow and has hair all over her body." Another pointed out that vaccination had been discontinued in his part of the country "because those who had been vaccinated bellow like bulls."

Simpson carried his illustration further and told of the attempted frustration of advancement in the field of agriculture. There had been strong opposition to the introduction of the winnowing machine to separate chaff from grain. This process had formerly been carried out by throwing grain into the air and allowing the wind to carry the chaff away. "Winds," it was argued by those opposed to the innovation of farm machinery, "were raised by God alone, and it was irreligious in man to attempt to raise wind for the aforesaid purpose for himself, and the efforts of his own." One clergyman had debarred from communion such of his flock as used the winnowing machine.

Dr. Stobie practises in Belleville, Ont.

He also mentions the opposition against the building of the Panama Canal. In the 16th Century, a priest by the name of Ascot brought forward the following reason against it:

> I am of the opinion that human power should not be allowed to cut through the strong and impenetrable bounds which God has put between two oceans, of mountains and iron rocks, which can stand the fury of the raging seas. And, if it were possible, it would appear to me very just that we should fear the vengeance of Heaven for attempting to improve that which the Creator in His Almighty will and providence has ordained from the creation of the world.

Simpson completed his arguments by a piece of almost irrefutable logic—certainly one of the most amazing statements. He more than met his opponents, for he took their weapons for his own use. He wrote:

> Besides, those who urge, on a kind of religious ground that an artificial or anesthetic state of unconsciousness should not be induced merely to save frail humanity from the misery and tortures of bodily pain, forget that we have the greatest of all examples set before us for following out this very principle of practice. I allude to that most singular description of the preliminaries and details of the first surgical operation ever performed on man which is contained in *Gen. II: 21:*
>
> "And the Lord God caused a deep sleep to fall upon Adam: and he took one of his ribs, and closed up the flesh instead thereof."
>
> In this remarkable verse the whole process of a surgical operation is briefly detailed. The passage is principally striking as affording evidence of our Creator Himself using means to save poor human nature from unnecessary endurance of physical pain. The first surgical operation was thus shown to have been performed with the patient under anesthetic.

This completed Simpson's religious controversy. He then turned to argue the point with the medical fraternity. Reluctance to accept progress, particularly someone else's brand of progress, was not peculiar to the clergy of Simpson's time. It apparently is a general characteristic of human nature, a kind of fear and uncertainty of one's own ability to cope with the innovation. Some of the medical men of that day possessed it, as they do today, to a high degree. Most people are conservative and instinctively hate radicals.

The professor of obstetrics of Dublin University wrote Simpson in the following words:

> I do not believe that anyone in Dublin has as yet used ether in midwifery. The feeling is very strong against its use in ordinary cases, and merely to avert the ordinary amount of pain which the Almighty has seen fit, and most wisely, we cannot doubt, to allot to natural labor; and in this feeling, I heartily and entirely concur.

Simpson met this argument by replying:

> Suppose, for example, this statement referred to the first introduction of carriages into use. It would then read thus: I do not believe that anyone in Dublin has as yet used a carriage in locomotion. The feeling here is very strong against its use in ordinary progression, and merely to avert the ordinary amount of fatigue which the Almighty has seen fit, and most wisely, we cannot doubt, to allot to natural walking; and in this feeling, I heartily and entirely concur.

He went on and made application of this statement towards the first wearing of a hat and the first use of table forks, because they were as loudly opposed and decried as the modern employment of anesthetics. Disraeli tells us that the use of forks was so much reprobated that some preachers denounced it as an insult on Providence not to touch our meat with our fingers:

> Nature, herself, has provided us with fingers of flesh and bone and nerve and, consequently, is it not unnatural and impious in man to attempt, in his human pride and arrogance, to substitute for these artificial, metallic fingers of silver and steel?

However, with all the opposition from the medical men, Simpson was able to report within two years that between four and five thousand persons in Edinburgh, both for childbirth and surgical operations, had received

chloroform. Simpson fortunately lived to see the success of his efforts. He was honored locally and was also knighted.

At the same time that Simpson was fighting in Scotland, Dr. Channing of Boston was waging a similar war. An objection brought forward in America would seem ridiculous today if it were not for the fact that, as late as 1921, in the revival of "twilight sleep" the same objection was raised:

> The very suffering which a woman undergoes in labor is one of the strongest elements in the love she bears for her offspring. The maternal instinct was engendered by the mother's suffering.

This argument, I presume, was not sponsored by expectant mothers but by women well past the childbearing age, disappointed spinsters, and by men who saw the maternal instinct slipping away with the abolition of pain. The expectant mothers took their chloroform or ether if they could get it. No doubt they wondered what suffering the fathers underwent to attain their paternal love! Possibly some even wished for a revival of the ancient custom of some tribes when the father was hung up by the feet to dangle head down throughout the hours of his wife's labor!

In April, 1853, an event occurred that exerted a greater influence on popular acceptance of anesthesia in childbirth, not only in Great Britain but in the United States as well, than all the efforts of Simpson. Queen Victoria accepted chloroform for the delivery of her seventh child, Prince Leopold. She again, in 1857, accepted it for her confinement. Formal opposition ceased in Great Britain thereafter and chloroform was often referred to as anesthesia *à la reine*.

Chloroform is used in the same way today in obstetrics, as it was in Simpson's day. For long surgical operations it is not used so commonly since many new anesthetics have been discovered. Local blocking of the nerve impulses to the brain by novocain (without putting the patient to sleep) is extensively employed either alone or augmented by nitrous oxide gas or ether. A relatively recent method is spinal anesthesia. This is accomplished by injecting a very small quantity of novocain into the fluid that surrounds the spinal nerves before they leave the spinal cord. This deadens all sensation below the point of injection but it cannot be employed above the diaphragm because one cannot, even temporarily, suspend the action of the muscles of respiration.

The mortality rate from anesthesia is relatively low. The press, in an effort to dispense what they consider to be interesting news to the public, tends to report, with headlines, every death that occurs before patients regain consciousness as being due to the anesthetic. Actually, it has been established that these deaths are almost always due to the fact that the operations were undertaken as a last desperate effort to save life. The public has been given a very wrong impression of anesthesia and many, consequently, are terrified to undergo an operation.

The art and science of anesthesia has advanced a great deal in the past 20 years. Modern anesthesia has done more to advance surgery than the actual advances of surgery itself have accomplished. The field of operability has been enlarged, operations have been made possible and safer, especially in the aged. Probably the greatest contribution has been the employment of curare—a drug originally used by the Indians to poison their arrows. When purified and administered in small doses it can be made a very valuable piece of the anesthetist's armamentarium. It releases the connection between the nerves and the muscles temporarily, resulting in relaxed muscles which are so essential to good surgery.

During the past two decades considerably more attention has been paid to the amount of blood lost during the third stage of labor. A method for accurately measuring this blood loss has been evolved. On this basis, any loss in excess of 1 per cent of the patient's weight must be considered a postpartum hemorrhage.

Aux Infirmières Canadiennes-Françaises

L'Infirmière Hygiéniste et la Santé Mentale

J. E. A. Marcotte, M.D.

Dans une brochure modeste, mais constituant dans l'ensemble une documentation intéressante, publiée en juin, 1950, par la Canadian Public Health Association et intitulée *Report of the Study Committee on Public Health Practice in Canada*, on trouve un bref—trop bref même—chapître sur la Santé Mentale dans lequel la plus large part des considérations et des recommendations a trait à la pratique de l'hygiène mentale par l'infirmière hygiéniste dans le domaine de l'hygiène publique.

Une dirigeante de nos infirmières hygiénistes du Québec m'a demandé de commenter cet exposé des enquêteurs de la Canadian Public Health Association, plus spécialement la partie concernant la collaboration active de l'infirmière hygiéniste à l'hygiène mentale.

On me permettra de souligner que le commentaire qui va suivre est exclusivement l'expression de mes vues personnelles basées sur une longue période d'étude, de pratique, et d'enseignement de l'hygiène mentale.

D'UN POINT DE VUE général d'abord, les rapporteurs de la Canadian Public Health Association, bien qu'explicitement ils soient d'une discrétion dont il faut les féliciter, nous laissent l'impression que la santé mentale n'a pas occupé une bien large place dans les préoccupations des hygiénistes publics jusqu'à tout dernièrement, que le programme d'hygiène mentale est incomplet et vague, qu'enfin il ne paraît pas exister entre les hygiénistes publics et les spécialistes de l'hygiène mentale la sorte de rapports indispensables à une collaboration fructueuse dans la recherche de la santé mentale.

Si l'on s'arrête à certaines considérations du rapport, il apparaît clairement qu'en définitive ce sont surtout les services de santé publics municipaux qui ont fait quelque chose pour la santé mentale. C'est une justice qu'il convient de leur rendre. Mais on est également porté à croire que les progrès de l'hygiène mentale auraient été plus rapides avec la collaboration active des universités, des facultés de médecine surtout, et des gouvernements provinciaux.

C'est avec plaisir que je constate que les rapporteurs insistent sur l'aspect préventif de l'hygiène mentale, sur l'importance et l'urgence de dépister et prévenir à bonne heure les troubles de comportement de l'enfance qui sont susceptibles de dégénérer en anomalies du caractère ou de la personnalité, incompatibles avec une saine adaptation, critère de la vraie santé mentale, à l'âge adulte.

C'est sur ce terrain et celui-là seulement, selon moi, que s'effectueront l'entente et l'union entre les hygiénistes publics, médecins et infirmières, d'une part, et les spécialistes de l'hygiène mentale, psychiatres, psychologues, d'autre part. A condition que les premiers se convainquent que la personne humaine n'est pas constituée par des compartiments étanches, l'un pour le physique et l'autre pour le psychisme, mais qu'elle est un tout avec des réactions d'aspects différents que l'on désigne conventionnellement par les termes "physique" et "mental"; à condition que les seconds, les psychiatres surtout ne craignent pas de chercher et de

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préparer des collaborateurs utiles hors leur domaine.

Et sur ce point, il faut signaler encore dans ce rapport que l'on insiste avec justesse sur l'aspect éducatif du rôle des hygiénistes mentaux en hygiène publique. Cependant, je ne puis abonder complètement dans le sens des rapporteurs qui paraissent prétendre (je traduis peut-être mal) que le programme d'hygiène mentale, en fonction d'un organisme d'hygiène publique, devrait s'appliquer de façon prédominante à l'éducation des hygiénistes publics. A mon sens, la clinique psychologique et psychiatrique, permanente ou ambulante, reste le moyen de prévention par excellence, parce que le grand public y réfère, et le fera encore longtemps, une quantité encore trop considérable de problèmes trop avancés pour que les simples conseils et directives, même les plus judicieux, de la catégorie que pourront fournir les hygiénistes publics dûment renseignés, suffiront à faire rentrer dans l'ordre. On semble croire, dans le rapport, que la clinique d'hygiène mentale n'existe que pour les francs névrotiques ou les prépsychotiques. En réalité, un grand nombre d'enfants qui ne présentent que des problèmes de conduite simple, en réaction à leur milieu, sans atteinte de la personnalité, ont besoin, pour se ré-adapter, de séances de traitement psychologique spécialisé qui nécessitent un temps que ne pourraient leur donner les hygiénistes publics sans négliger le reste de leurs activités; leur préparation serait d'ailleurs inadéquate.

Je n'en reste pas moins d'accord avec les rapporteurs de C.P.H.A. que les fonctions quotidiennes des hygiénistes publics, médecins et infirmières, dans les cliniques, les écoles, les visites à domicile, offre de multiples et constantes occasions de travailler d'excellente façon au développement de la santé mentale, d'où cette judicieuse recommandation d'initier ce personnel à l'hygiène mentale.

Voyons maintenant ce qui concerne plus particulièrement le rôle de l'infirmière hygiéniste dans le champ d'action de l'hygiène mentale.

D'après ce rapport l'infirmière hygiéniste, dans une large majorité des services étudiés, paraît avoir cumulé les fonctions de travailleuse sociale ordinaire et psychiatrique, de conseillère psychologique, d'infirmière psychiatrique et même de psychotechnicienne, puisque dans cinq des huit districts urbains et dans cinq des six districts ruraux où se pratiquait de l'hygiène mentale, elle était chargée de préparer l'histoire de cas, de présenter les patients à la clinique, et de faire après réception des rapports des visites consécutives (follow-up) qui ont pour objet d'interpréter aux intéressés les directives données et de veiller, dans une certaine mesure, à ce qu'elles soient mises en pratique. Enfin, dans un des districts urbains, la mention que le personnel de l'hygiène mentale comprenait des infirmières spécialisées signifie, et j'ai de bonnes raisons de le croire, que ces demoiselles avaient à administrer certains tests psychologiques.

L'opportunité et l'efficacité de ce rôle chargé et complexe de l'infirmière hygiéniste en hygiène mentale, dans le passé récent et dans le futur, doivent être examinées en fonction de deux critères: (1) la nature du travail à accomplir; (2) la préparation habituelle et complémentaire de l'infirmière.

L'histoire de cas qui éclaire et structure, quand elle est bien faite, les problèmes présentés par les sujets dont la santé mentale paraît menacée ou compromise, constitue une partie vitale et par conséquent indispensable de l'étude de la très grande majorité des cas. Elle nécessite des notions de bases assez complètes en sociologie et en psychologie, ainsi qu'un entraînement pratique plus long qu'on ne veut le reconnaître d'habitude. Elle diffère en hygiène mentale de ce qu'elle est dans le plan strictement médical, surtout en ce qu'elle requiert des aptitudes et un entraînement à juger à priori de la capacité d'expression et des tendances plus ou moins conscientes à la dissimulation chez certaines personnes.

L'interprétation des résultats d'examens et d'entrevues psychologiques

et psychiatriques, la présentation des directives émises aux intéressés en termes et aux moments les plus appropriés, n'auront l'efficacité qu'on est en droit d'en attendre que si les travailleuses chargées de s'en acquitter possèdent de solides notions de psychologie normale et anormale de la personnalité, ainsi qu'une réelle connaissance, basée sur l'expérience, des groupements sociaux à mentalités différentes avec lesquels se font les contacts. Le tact et l'habitude générale des rapports entre hygiénistes publics et masses populaires ne peuvent remplacer cette préparation préalable. Une interprétation erronnée ou intempestive peut causer un dommage irréparable. Il faut même parfois assez de connaissances, et la sûreté qui en découle, pour discerner entre l'opportunité et la contre-indication de suivre les directives de certains spécialistes.

La technique des tests psychologiques que l'on confie à certaines infirmières attachées à des organismes d'hygiène mentale est assez facilement et rapidement maîtrisable; mais pour se tirer d'affaire dans les multiples occasions imprévues de déterminer la validité de certaines réponses, comme pour faire de nombreuses et précieuses constatations révélatrices de la personnalité des sujets examinés dans la situation du test, des notions étendues de psychologie de la personnalité sont encore requises. Ce sont ces connaissances qui rendront le travail psychométrique tolérable après une courte période de nouveauté, qui protégeront de l'impression de routine mécanique si dangereuse à l'efficacité des opérateurs.

Il n'est pas nécessaire d'insister plus longuement sur la nature du travail qui incombe à l'infirmière hygiéniste, dans le champ d'action de l'hygiène mentale, pour se rendre à l'évidence qu'il requiert une préparation un peu spéciale.

Nos écoles d'infirmières procurent-elles cette préparation à leurs élèves; offrent-elles seulement des notions élémentaires de santé et d'hygiène mentale dans leur programme de cours? Je crois être assez renseigné pour répondre dans la négative en ce qui concerne la majorité de ces écoles pourtant bien accréditées. A certains endroits, on donne des notions de psychiatrie qui tendent surtout à faire concevoir la santé mentale dans son acception négative d'absence d'anomalies mentales graves. A d'autres plus rares, on fait la louable innovation d'ajouter au programme quelques leçons sur l'hygiène mentale, mais en nombre encore trop insuffisant pour qu'elles soient d'une utilité pratique immédiate.

Certains contacts avec des diplômées d'autres provinces du Canada me laissent croire que ça n'est guère mieux que dans la nôtre.

Quelles ressources offrent les cours avancés de perfectionnement de nos écoles d'infirmières hygiénistes? Celle de l'Université de Montréal, il me fait plaisir de le reconnaître, a inscrit à son programme régulier des cours de psychologie de la personnalité et d'hygiène mentale: ces cours, par leur nombre et leur qualité, mettent les infirmières hygiénistes en mesure de rendre de précieux services à l'hygiène mentale mais dans le domaine général de l'hygiène publique seulement; et l'enthousiasme avec lequel ils sont suivis par la grande majorité des élèves prouvent bien qu'ils répondent à des besoins réels. Cependant, je ne suis pas prêt à concéder que c'est là une préparation suffisante pour faire la plus grande partie du travail d'hygiène mentale qui paraît devoir être confié à l'infirmière hygiéniste d'après les commentaires et les recommandations du rapport de C.P.H.A.: l'entraînement pratique, pour un item, fait à peu près complètement défaut.

D'ailleurs, les écoles d'infirmières hygiénistes ne se cachent pas pour déclarer que leur programme ne vise nullement à former des spécialistes de l'hygiène mentale et c'est dans l'ordre. Pourquoi, en effet, prendrait-on des infirmières hygiénistes de formation complète pour les transformer en spécialistes hybrides mi-travailleuses sociales et mi-psychologues? Ce serait, à mon sens, les

diminuer, les enlever à une profession dont la grande et indispensable mission ne le cède à aucune autre en importance, contribuer à leur affaiblissement numérique que l'on déplore pourtant.

Il n'en reste pas moins vrai que l'hygiène mentale demeure de nécessité un travail d'équipe, que parmi les membres de cette équipe l'infirmière hygiéniste doit occuper une place importante, que sa collaboration est précieuse, mais à condition qu'on la lui fasse fournir dans son domaine propre.

A mon sens, le rôle de l'infirmière hygiéniste en hygiène mentale, en fonction de son travail régulier en hygiène publique, peut et doit consister dans le dépistage occasionnel des troubles de comportement chez les enfants d'âge pré-scolaire et chez les écoliers, et leur acheminement vers les spécialistes de l'hygiène mentale, mais surtout et de façon constante dans la diffusion et la vulgarisation des notions élémentaires de psychologie de l'enfance, des principes positifs de santé mentale, dans un but de prévention, auprès des mères dans les cliniques et les écoles, au cours des visites quotidiennes dans les foyers.

Des infirmières hygiénistes, attachées à un service d'hygiène mentale, pourraient remplir le rôle d'éducatrices et d'entraîneuses auprès de leurs compagnes des services d'hygiènes généraux beaucoup mieux que des travailleurs spécialisés de l'hygiène mental relevant d'autres professions.

Il est bien possible que je ne tienne pas compte, dans mon commentaire, de certaines considérations d'importance dans le plan administratif de l'hygiène publique: c'est qu'elles restent pour moi secondaires au droit de l'individu comme des masses à la santé mentale.

In the Good Old Days

(*The Canadian Nurse*, October 1911)

"Until the beginning of the 18th century there was no systematic practice of artificial feeding for babies. If the natural food of the mother was not available, a wet nurse was procured when possible and, if one was not to be had, it is to be supposed that the child died . . . The mortality among infants was, of course, very great — almost incredible to our modern ideas . . . In the middle of the 17th century it sometimes happened that half of the births of a year were wiped out by infantile diseases."

* * *

"A man must have faith in himself to be of any use in the world. There may be very little on which to base it — no matter; but faith in one's powers, in one's mission, is essential to success." — Sir William Osler.

* * *

"Will some of the nurses give us their views on the advisability of having a fixed tariff or fees for private duty nursing as against the sliding scale?"

* * *

"We do not wish to frighten nurses away from this glorious country, for such it is, but at present, as far as Southern Alberta is concerned, we are in a position to say that nurses are coming here too fast to insure work for all."

* * *

"A slice of bread with the crusts trimmed off may be dampened with cold water, sprinkled over with ground mustard, covered with a thin cloth, and used as a mustard plaster when needed very quickly and the usual things are not at hand. (This blisters the skin more readily than the plaster made with white of egg.)"

* * *

"A convenient night light for a sick-room in a country house in which there is neither gas nor electricity may be invented by hanging a lantern from a hook screwed into the bottom of an upper window sash on the outside. The light within the room may be regulated by raising or lowering the inside shade. This obviates the heat and odor from an ordinary lamp in the room."

Clean dusty candles with cloth saturated with alcohol.

Trends in Nursing

As Others See Us

SOME YEARS AGO the *American Journal of Nursing* sought to obtain the views of the public on nursing. They employed as their counsel the head of one of the leading public relations organizations in New York to undertake this project. There followed a series of articles on the results of the study, all very interesting, some quite revealing on what the public actually expected of nurses and nursing.

Now we find both the Canadian Medical Association and the American Medical Association have undertaken a similar line of action. The C.M.A. publishes a monthly public relations bulletin entitled *On Call.* This bulletin is prepared by a public relations counsel employed by the C.M.A. They have recently started a series entitled "As Others See Us." Representatives of such groups as press, labor, hospital administrators, and the Canadian Nurses' Association have been asked to state their views on how the public relations of the medical profession might be improved with particular reference to the groups they represent.

Each group has been asked to criticize constructively, of course. Ideas and suggestions have also been sought. This, it must be admitted, is a courageous and objective approach on the part of the medical profession to their problem and would appear to be an excellent means of helping the profession to improve its relations with these groups and its service to society.

As requested by our medical confrères, the C.N.A. submitted a 1,200-word article on what we believe the Canadian Medical Association may do to assist nursing and nurses. It is earnestly hoped that the suggestions which were offered may prove mutually helpful in the more effective and complete achievement of our common purpose.

The American Medical Association has announced the appointment of a lay advisory committee representing industry, labor, agriculture, education, the law, and the clergy. Purpose of the committee will be to advise the association in matters of medical care and to present the viewpoint of the general public. "The men and women who serve on the committees will be divorced from politics and will be serving unselfishly for the betterment of health and medical care for all the people," according to Dr. Louis Bauer, president-elect of the A.M.A.

It is hard to imagine how a professional association could take a more constructive step toward building better public relations than this one, which takes the public into its confidence, so to speak, and asks for help. Too often, the public relations efforts of such special interest groups consist wholly of public pronouncements insisting that everything is wonderful and anybody who says different is a leftist. The appointment of a lay advisory committee is wholesome evidence that the association is taking the problem-solving rather than the problem-denying approach. That fact by itself should win more real public support than the most turgid pronouncement of virtue.

Nursing Research in Canada and the United States

Everyone is a little tired of hearing about the shortage of nurses or of nursing. How great is the shortage? How effective is the use being made of available nurse-power? What are the functions of nurses? These and many related questions are constantly being bandied about.

The time has at last arrived when some positive steps are being taken to find the real answers to these

queries. Nurses, generally speaking, are anxious to have research projects carried out in relation to nursing education and nursing practice. The structure study of the C.N.A., which is now underway, is essentially a study in relationships. A study and evaluation of the Demonstration School of Nursing at Windsor is to be undertaken shortly. Plans are presently being developed jointly by the Committee on Provision of Nursing Care and the Division of Research, Department of National Health and Welfare, for an activity analysis study of the head nurse in a large hospital.

Briefly the purpose of this study is to determine what are the present activities of the head nurse. How is the head nurse's time distributed among her present activities? What part of her time is being spent in non-nursing and non-head-nurse activities? Can any of these be done by other personnel?

As a result of this information, it is expected that suggestions would be made for a reallocation of functions to achieve greater efficiency. Watch for more information in the *Journal* concerning this study as it progresses. This is we hope just a beginning in nursing research in Canada.

The American Nurses' Association, as part of its nation-wide effort to improve nursing service, has announced the first five grants to be made under its program of research into nursing functions, which is being financed entirely by funds collected or allocated by state nurses' associations. The first grant has been made to the California State Nurses' Association and it is hoped to determine the respective functions and spheres of work of professional nurses, practical nurses, and auxiliary nursing workers. Another grant is being made to the Boston Psychopathic Hospital for a two-year investigation into the effect upon mentally ill patients of such factors as the changes in number and type of nursing staff and of the effects of many normal daily events. Other grants provide for a pilot study to the New York Conference Committee for the Improvement of Nursing Care and for several time and motion studies in widely scattered centres throughout the American States.

Exchanging Ideas

In a recent issue of the British journal—*Nursing Times*—mention is made of the tremendous benefit to nurses derived from visiting hospitals and public health services in other countries. Every year many nurses from abroad visit British hospitals and the same is true of Canada. One hopes that, even with a fleeting glimpse of our nursing work, foreign nurses may gain new ideas but it is not until we hear of their impressions, good or bad, that the country visited derives most benefit from their visits.

Some developments, which seem to impress visitors to Britain, are the strides made in occupational therapy and rehabilitation which begins even in bed, with exercises under supervision, and continues at places like the miners' rehabilitation centres where they go to complete their recovery. Another much visited centre by visitors is that of Roffey Park, Sussex, where patients from industry may go at the earliest signs of mental strain and receive special care and treatment to prevent serious illness.

New impressions are stimulating and give an impetus to life but the only real way to study a country's system of nursing is to live and work there. Exchanges of nurses are arranged by the professional organizations of the countries and many nurses have profited by the experience they have gained in other countries. There are not only professional opportunities but also cultural ones and a sure way to bring countries together is for those in the same professions to be able to meet each other and to work and to relax together.

There are immense opportunities for a nurse to work for a better understanding between different nations and for a free exchange of ideas, especially if she realizes that she works in a new country not only to receive, but to give, and to bring home with

her the best of what she has seen and a richer appreciation of her own traditions of nursing.

World Health Organization

Miss Daisy Bridges, executive secretary, International Council of Nurses, and Miss Marjorie Duvillard, directress, Le Bon Secours School of Nursing, Geneva, represented the I.C.N. at the meeting of Fourth World Health Assembly held in Geneva in May, 1951.

Following the plenary and business sessions, the Health Assembly broke up into discussion groups, the three main subjects being:

1. Undergraduate medical education.
2. Training of public health personnel.
3. Training of auxiliary personnel.

During the progress of the discussion Miss Duvillard spoke on the ways in which the integration of public health is being carried out in nursing schools and the executive secretary made a general pronouncement on the necessity for medical and nursing education to follow the same pattern.

She quoted from the report of the first session of the Expert Committee on nursing of the World Health Organization, in which the following statement occurs:

> In countries where medicine is highly developed and nursing is not, the health status of the people does not reflect the advanced stage of medicine — nursing is the vitalization of the Health Service.

Miss Bridges went on to say that it seemed essential that medical education and nursing education should proceed along similar lines and, for this reason, nursing education, recognizing the trends in medicine, has advocated the integration throughout the whole of the nursing course of the social, preventive, and mental health aspects, by means of staff education, by teaching the normal and the abnormal together, and by introducing the student, quite early in her training, into out-patient clinics and into the homes of the people, in order to give sick care as well as to teach the principles of health. This is now being successfully carried out in many schools in various part of the world.

Nine nurses, representing various international and national organizations, attended the assembly. It is hoped that soon all national delegations will bring with them to the assembly a nurse adviser, in order that the nursing profession may be more adequately represented and that nurses may be in a position to contribute in discussions on their own specialties. In this connection it is of interest to note that the Swedish Nurses' Association shared with the Swedish Government the expenses of Miss Majsa Andrell, chief nurse, Department of Health, Sweden, in order that it might be possible for her to remain with the Swedish delegation during the whole three-week period of the assembly.

There is increasing evidence at every assembly that WHO looks to the non-governmental organizations, which are in official relationship to assist the organization through consultation, by the making of special studies, and by giving wide publicity to the activities of WHO. The I.C.N., during its three years of relationship, has used every effort to fulfil its responsibilities in this connection in order to deserve the privileges of such relationship; and there is no doubt that with our Headquarters acting as an International Information Bureau on Nursing, with the Florence Nightingale International Foundation and our International Committees undertaking special projects, and by drawing on the knowledge and experience of our large and varied membership, we can make, and should be able increasingly to make, a valuable contribution to the cause of world health.

Following the Fourth World Health Assembly, which completed its sessions on May 28, the following message was received by the executive secretary of the I.C.N. from Dr. Brock Chisholm, the Director-General:

> I wish to express my thanks for the active participation of the International Council of Nurses in the technical

discussions held during the Fourth World Health Assembly. These discussions were arranged in order to obtain a thorough exchange of views and experiences and to stimulate interest in problems related to the training of competent health personnel.

The valuable contribution of your organization helped to achieve this purpose and was very much appreciated by all who were responsible for the talks.

Educational Programs for International Students

A representative of the Educational Programs Branch, Division of International Health Department, United States Public Health Service, in the person of Miss Mary Forbes, nurse consultant, visited National Office recently to confer on the possibility of sending French-speaking nationales from Indo China and other underdeveloped countries, to which the United States Government is offering technical assistance, to Canadian universities for courses in nursing education and public health nursing. Miss Forbes was accompanied by Miss Helena Reimer of Winnipeg, Man., who has recently been appointed by WHO to Cambodia, Indo China.

Conferences were held at which representatives from the University of Montreal and Marguerite d'Youville, public health nursing departments, etc., were present and arrangements were made for special programs to be given, such programs to be suited to the needs of students from the countries concerned.

Miss Forbes also visited various institutions and health agencies in Montreal and Quebec for the purpose of determining the standards of service.

International Meetings

At the *Seventh International Hospital Congress*, held in Brussels July 15-21, the I.C.N. was represented by Mrs. B. A. Bennett, chairman, I.C.N. Nursing Service Committee.

At the Fifth General Assembly of the *World Medical Association*, held in Stockholm, Sweden, September 15-21, the I.C.N. was represented by the president, Miss Gerda Hojer; Miss Majsa Andrell, chief nurse of the Department of Health in Sweden; and Miss Elizabeth Dillner, principal of the Uppsala Sjukskoterskehem.

At the *Sixth Inter-American Red Cross Conference*, to be held in Mexico City October 1-15, the I.C.N. will be represented by Miss Matilda Prida, National Associate representative in Mexico, and Miss Mercedes Miranda, vice-president, Mexican Nurses' Association.

At the Fourth International Congress on Mental Health, sponsored by the *World Federation for Mental Health*, to be held in Mexico City, December 11-19, the I.C.N. will be represented by Miss Matilda Prida and Miss Fernanda del Viller, head nurse at the Maximino Avila Gamache Health Centre.

We look forward to receiving interesting reports of all these important international gatherings.

International Essay Competition

The names of ten winners of the International Essay Competition, organized under the auspices of the United Nations Public Information, were recently announced by the Assistant Secretary-General for Public Information.

Each contestant had been required to submit an essay of approximately 2,000 words on "The United Nations and the Evolution of the Concept of International Solidarity."

The winners, all of whom are *bona fide* members of non-governmental organizations active in the U.N. field, will receive transportation between their homes and United Nations Headquarters plus an allowance of $10 a day for 30 days while they are in New York. They will be granted all facilities for studying the work of the Secretariat and of any organs meeting at the time.

The winners, nine men and one woman, all of them between 20 and 35 years of age, are from Australia, Costa Rica, Cairo, France, India, Iran, Liberia, Paraguay, Sweden, and England.

Orientation et Tendances en Nursing

Aux Yeux des Autres

Il y a quelques années, l'*American Journal of Nursing* chercha à connaître l'opinion du public sur la profession d'infirmière. Pour mener à bonne fin cette enquête, un conseiller fut choisi parmi les officiers en relations extérieures d'une éminente compagnie de publicité. Une série d'articles furent publiés sur le résultat obtenu, dont quelques uns firent connaître ce que le public attendait des infirmières.

Aujourd'hui ce sont les médecins qui sondent l'opinion publique. La "Canadian Medical Association" et l' "American Medical Association" font une enquête semblable. Le C.M.A. publie chaque mois un bulletin appelé *On Call*. Le bulletin est préparé par un conseiller en relations extérieures à l'emploi du C.M.A. Récemment une série d'articles y étaient publiés sous le titre "Tel Que les Autres Nous Voient."

L'on s'est adressé à plusieurs chefs de groupes—journalistes, ouvriers, administrateurs d'hôpitaux, et à l'Association des Infirmières du Canada—pour obtenir leur opinion sur la façon d'améliorer les relations entre les médecins et les membres des groupes représentés. L'on a demandé aux chefs de groupes consultés de faire une critique constructive, d'apporter des idées, et de faire des suggestions.

Il faut admettre que la profession médicale, en cherchant objectivement la solutions de ses problèmes, fait preuve de courage. Cela semble un excellent moyen d'améliorer à la fois les services envers les malades et les relations entre médecins et les diverses classes de cette société.

L'A.I.C., se rendant à l'invitation des médecins, a fait des suggestions sur la façon dont les médecins peuvent contribuer à l'amélioration des soins à donner aux malades et comment ils peuvent aider les infirmières. Cet article de 1,200 mots il faut l'espérer aidera les médecins et les infirmières à atteindre le but commun de leur profession respective.

L' "American Medical Association" vient de nommer un comité consultatif, composé de représentants de l'industrie, du travail (ouvriers), de l'agriculture, de l'éducation, du droit, et du clergé. Le but de ce comité est de renseigner l'association sur les questions de soins médicaux et de représenter le point de vue de la population en général.

Enfin la Réponse Tant Cherchée!

Tout le monde est fatigué d'entendre dire qu'il manque d'infirmière. Combien en manque-t-il? Le rendement de l'infirmière est-il toujours employé au soin du malade? Quelles sont les tâches que l'infirmière doit accomplir? Ces questions et bien d'autres qui s'y rattachent ont été criées dans tous les coins du pays.

Enfin l'on peut annoncer que des mesures sérieuses ont été prises pour donner une réponse vraie à chacune de ces questions. Un comité de l'Association des Infirmières du Canada, chargé spécialement d'étudier les moyens à prendre pour assurer aux malades des soins adéquats (Committee on the Provision of Nursing Care), conjointement avec le Département des Recherches du Ministère de la Santé et du Bien-Etre National, est à mettre au point un projet d'analyse des tâches de l'hospitalière (head nurse) dans les grands hôpitaux. En plus, l'A.I.C. poursuit son étude sur la structure de cette association ou d'une façon plus explicite sur la manière dont les différentes provinces, qui composent l'A.I.C., sont disposées envers les unes et les autres, sur la manière d'envisager de conduire le nursing dans chacune des provinces. C'est une étude de relations extérieures. Une étude et une évaluation de l'Ecole de Démonstration de Windsor doit être entreprise prochainement. Surveillez bien votre *Canadian Nurse* —le compte-rendu de certaines de ces activités apparaîtra prochainement. Voilà un premier pas dans le domaine de la recherche en nursing.

Aux Etats-Unis de même des études très intéressantes se poursuivront. L'Association des Infirmières de California entreprend une étude pour déterminer les fonctions respectives des infirmières professionnelles, des "practical nurses" et des auxiliaires ou aides malades. Le "Boston Psychopathic Hospital" fera durant deux ans une étude sur l'effet que produisent, sur les malades mentaux, certains facteurs tels que les changements dans la quantité et la qualité du personnel infirmier et sur plusieurs événements quotidiens. A

New York un comité spécial, chargé d'étudier les moyens à prendre en vue d'améliorer les soins aux malades, se réunira plusieurs fois. L'étude de ce comité portera surtout sur l'analyse du mouvement.

Toutes ces études peuvent se faire grâce à la générosité des infirmières. Les associations de chaque état ont demandé des contributions spéciales à leurs membres ou ont pris des sommes importantes à même leurs réserves.

Echange d'Idée

Récemment dans une revue anglaise sur le nursing (*Nursing Times*), un article attirait l'attention des infirmières sur les bénéfices que l'on peut tirer en visitant les hôpitaux et les organisations de santé des pays étrangers. C'est un fait. Toutes les infirmières britanniques qui visitent le Canada comme les infirmières canadiennes visitant la Grande-Bretagne sont unanimes à dire que même une visite rapide dans les hôpitaux peut leur apporter des idées nouvelles. Lorsque ces infirmières font connaître leurs impressions—bonnes ou mauvaises, les pays visités retirent également des bénéfices de ces visites.

Ce qui a le plus impressionné nos visiteuses canadiennes en Grande-Bretagne c'est l'avancement des centres d'occupation therapeutique et de réhabilitation. Cette réhabilitation, par exemple, dans des centres affectés aux mineurs commence par une série d'exercices surveillés lorsque le malade est encore au lit. Un autre endroit bien visité est Roffey Park, Sussex, où les employés de l'industrie peuvent se diriger au premier signe de surmenage mental. Des impressions nouvelles sont un stimulant dans la vie quotidienne mais la vraie façon de connaître le nursing d'un pays c'est d'y vivre et d'y travailler.

Des échanges d'infirmières entre certains pays peuvent être faits par l'entremise des associations nationales; en plus d'acquérir une expérience professionnelle, quel excellent moyen de culture; et aujourd'hui que tout homme est citoyen du monde, une meilleure connaissance d'autrui est souvent un facteur de meilleure entente.

Organisation Mondiale de la Santé

Lors de la quatrième assemblée de l'O.M.S., Mlle Daisy Bridges, secrétaire du Conseil International des Infirmières, et Mlle Marjorie Duvillard, directrice de l'Ecole d'Infirmière "Le Bon Secours" à Genève, représentaient le C.I.I.

Après les assemblées préliminaires et d'affaires, les membres formèrent des petits groupes afin de discuter plus facilement les trois questions à l'étude, à savoir:

1. L'instruction donnée aux étudiants en médecine.
2. La formation du personnel en hygiène publique.
3. La formation du personnel auxiliaire.

Durant la discussion, Mlle Duvillard parla sur les dispositions et moyens pris par les écoles d'infirmières pour intégrer l'hygiène publique dans le programme des écoles. La secrétaire parla sur la nécessité d'orienter le cours d'infirmière parallellement à celui de l'étudiant en médecine. Elle cita cette affirmation qui fut faite lors de la première session du Comité du Nursing de l'O.M.S.:

"Dans les pays où la médecine est très avancée et où le nursing l'est beaucoup moins, l'état de santé de la population ne permet pas de juger de la valeur de la médecine—c'est le service des infirmières qui donne de la vigueur aux services de santé."

Mlle Bridges, en disant qu'il semble essentiel que l'éducation des médecins et celle des infirmières soient orienté parallellement, veut dire selon les tendances actuelles en médecine. Elle recommande d'introduire dans tout le cours de l'infirmière l'aspect social, l'aspect préventif, et l'aspect de l'hygiène mentale.

Pour atteindre ce but elle conseille d'abord des cours ou conférences au personnel diplômé et chez les étudiantes un stage, au début du cours, dans les dispensaires et des visites dans les familles afin d'y donner des soins et d'y faire l'enseignement des principes de l'hygiène.

Le Directeur-Général de l'O.M.S. remercie le C.I.I. pour leur participation active lors de la quatrième assemblée de l'O.M.S.

Etudiantes Internationales

Une représentante de la "Educational Programs Branch, Division of International Health Department, United States Public Health Service," Mlle Mary Forbes, infirmière consultante, visitait les bureaux de l'Association des Infirmières du Canada. Désirant envoyer des personnes de langue française d'Indo-Chine et d'autres pays, auxquels les Etats-Unis accordent une assistance, suivre des cours d'infirmières et des cours post-scolaires dans des universités, Mlle Forbes étudia sur place ce que notre province avait à offrir. Des conférences tenues à l'Institut Marguerite d'Youville, à l'Uni-

versité de Montréal, etc., lui permirent de discuter des programmes, des arrangements spéciaux a y apporter en vue de répondre aux besoins particuliers des élèves venant de pays peu développés.

Mlle Forbes fit de nombreuses visites dans les hôpitaux et organisations de santé tant à Montréal qu'à Québec afin de déterminer les standards de nos services.

Congrès Internationaux

Au septième *Congrès International des Hôpitaux* tenu à Bruxelles en juillet, le Conseil International des Infirmières était représenté par Mme B. A. Bennett.

Le *Congrès Mondial des Associations Médicales* était tenu à Stockholm, Suède, en septembre. Mlle Gerda Hojer, présidente du C.I.I., Mlle Majsa Andrell, infirmière en chef du Ministère de Santé de Suède, et Mlle Elizabeth Dillner étaient nos représentantes.

Mlles Matilda Prida et Mercedes Miranda seront les déléguées du C.I.I. au *Congrès Inter-Américain de la Croix-Rouge* lequel se tiendra à Mexico en octobre.

Le *Congrès International de l'Hygiène Mentale* se tiendra en décembre à Mexico. Deux infirmières y seront déléguées par le C.I.I.—Mlles Prida et Fernanda del Villar.

Nous avons hâte de lire les intéressants rapports que nous feront parvenir ces infirmières.

Les Nations-Unies

Un concours intéressant, auquel prirent part neuf hommes et une femme habitant l'Australie, Costa-Rica, le Caire, la France, l'Inde, l'Iran, le Liberia, le Paraguay, la Suède, et l'Angleterre, vient de se terminer. Chaque participant devait soumettre une composition d'environ 2,000 mots sur le sujet "Les Nations-Unies et l'Evolution du Concept de la Solidarité Internationale." Le lauréat recevra comme prix un passage gratuit de son pays à New-York et une allocation de $10 par jour durant un mois.

Annual Meeting in Alberta

The 33rd annual meeting of the Alberta Association of Registered Nurses was held in Banff, May 17-19, 1951, with approximately 200 members registered. Miss Frances Ferguson, president, was in the chair. Rev. Longsdale of Banff gave the invocation.

In her presidential address, Miss Ferguson welcomed all delegates. She felt that the program had been planned to give stiumlus to all on their return to their work. On behalf of the members present, Miss Ferguson expressed the pleasure of having Miss Gertrude Hall, general secretary, C.N.A., with us.

Rather than looking back, Miss Ferguson sought to have us look to the future. First, there was the insurance plan as offered by the North American Life and Casualty Co. Their plan had been endorsed by the association. Miss Ferguson stressed the need of all members getting behind it and giving it their support. She further reported on the excellent institutes and refresher courses held. From all reports received, there was a desire for more to be held during the coming year. The thanks of the association were extended to the Department of Extension at the University of Alberta for their cooperation and assistance in making these courses possible.

During the course of the year, Miss Ferguson stated, many requests for guidance and help to matrons of the smaller hospitals had been submitted. She stated that she had also been asked if a superannuation plan could not be instituted for all nurses. The suggestion was that it could be shared by the employer.

She pointed up to the valuable assistance given by Miss Smith, adviser to schools of nursing throughout the province. She felt that Miss Smith had been faced with many complex problems and that her advice had been very beneficial and well received.

Miss Ferguson commented on the newly-formed Psychiatric Nurses' Association and felt sure that every member would be watching its progress with interest. She explained that team nursing is now in progress at the University Hospital with gratifying results and, through cooperation, the nursing aide could well be a valuable member to this team.

The registrar's report, read by Mrs. Van Dusen, showed that the year had been one of significant progress and activity for the asso-

ciation as a whole. She commented on the resolution to include *The Canadian Nurse* in the annual fee which had been approved at the 1950 annual meeting. As of March 31, 2,013 members were automatically receiving their copies.

Mrs. Van Dusen reported that the Personnel Policies had been revised. Last December, a pamphlet containing the revisions was sent to each active member of the association and each employer in the province. Vulcan had formed a chapter on May 10 and one of their delegates was representing the newly-formed chapter at the convention. *News Letter* advertising to date had paid in the approximate sum of $900.

Membership was noted as follows. Active 2,001, compared to 1,904 in 1950; associate 1,934, compared to 1,760 in 1950; new inactive membership 195, compared to 150 in 1950.

The treasurer, Miss Morrison, reported the income for 1950 was $32,050. Expenditures amounted to $18,787, leaving a surplus of $13,262.

Miss Helen Peters reported that 28 students received financial assistance from the Dominion-Provincial Aid Grant.

In her report, Miss Margaret Cogswell outlined the progress of the Disability Plan, underwritten by the North American Life and Casualty Co. which had been approved at the annual meeting in 1950. From reports received from members at large, the solicitation had been poor on the part of the company. It was felt that the company had not carried out its end of the bargain in many instances and a resolution was sent to the head office in Minneapolis.

As chairman of the Nursing Aide Committee, Miss Ferguson reported that it had been approved by the Nursing Aide Advisory Council that grey caps and a distinctive pin be awarded to all certified nursing aides. "Training of Nursing Aides in Alberta," a 35-mm. filmstrip in color, has just been completed. This film is complimentary and may be obtained from the Department of Health Education. They have a full-time instructor on their staff who visits all the practice hospitals in a rotation plan of five weeks and so is able to assist staffs with the guidance of the trainees and assist the trainees to make adjustment. There are now 538 certified nursing aides in the province; in training April, 1951, 219. Classes are enrolled every five weeks. Approximate number in each class, 35; hospitals assisting in training, 17. Miss Ferguson stated that they cannot fill the requests of all the hospitals for nursing aides.

The report of the Legislation Committee proposed some changes to the A.A.R.N. By-Laws.

Dr. Pauline Jewett, who is undertaking the Structure Study for the C.N.A., was introduced to the meeting by Miss Ida Johnson. Miss Jewett gave a very interesting and informative outline on her work.

A panel on nursing care was introduced by Miss M. Robertson, Calgary. Those taking part in the panel were: Misses K. Morton, M. Arnett, M. Swinton, L. Ellard, and R. Greenfield. This panel proved both interesting and instructive.

Thursday evening, May 17, the banquet was held with well over 200 in attendance. Miss Gertrude Hall was guest speaker.

Friday morning was entirely devoted to sectional meetings, each group having a luncheon at noon. The afternoon session opened with a film — "Pay-Off in Pain." There was an audio-visual aide demonstration by C. C. Evoy, Department of Public Health. Civil defence was discussed by Col. Ted Brown. Miss Irene Kennedy, representative of the Department of Public Health, spoke on sickness surveys in the small towns and rural districts. The evening session opened with a panel — "Trends in Post-Operative Care." Those taking part in the panel were: Dr. Smith Gardiner, Miss M. Robinson, Dr. J. R. Frances, Miss Pauline Vock, Dr. J. Nickson. This was followed by a film — "Managing Fresh Wounds of Violence." Following the evening session, a coffee party was held and colored pictures of the Rockies were shown by the president of the Alpine Club.

Saturday morning opened with reports from the section meetings. Miss Frances McQuarrie, chairman of the Institutional Committee, stated that the main concern of the committee was to continue the education of the registered nurse. She also reported that Personnel Policies had been discussed at great length. Suggestions for projects for the coming year were considered. The group hope to study the book entitled "Nursing Service Research" by Miss Viola Bredenburg.

Miss Lois Kraemer reported the discussions of the matrons of small hospitals. She suggested that, in arranging the program, the matrons' difficulties seemed to have been forgotten, such as shortages of staff, which made

it necessary for her to stay home and do six jobs in the place of one. Unless something is done to meet the ever-growing needs of the small hospitals for staff, many of them will have to close. The matrons felt that too little representation had been given to them in various organizations. A committee was appointed, consisting of: Miss F. McWinney, Wetaskiwin, Mrs. B. Turner, Didsbury, and Miss Kraemer, chairman, to act as a corresponding committee with hospitals throughout the province. The group felt the need for a nurse adviser to matrons of small hospitals.

Miss Jean Brown, chairman of the Private Duty Nurses' Committee, stated it was agreed that all registries should work towards uniformity throughout the province. This could be done by having a set professional tariff for nurses. It was suggested that an orientation program for private duty nurses be considered The recommendations were referred to the Resolutions Committee.

Miss E. Bietsch, chairman of the Educational Policy Committee, presented the following resolutions:

1. That the Educational Policy Committee investigate the possibility of obtaining a sum of money, possibly a part of the Dominion-Provincial Grant, to pay service charges and transportation on films which various schools of nursing might wish to use but do not wish to purchase.

2. That the Educational Policy Committee in future consist of the following: Chairman of the sub-committee in the South, chairman of the sub-committee in the North, and the director of each school of nursing in the province. Also, that this committee ask Council to approach hospital boards through superintendents of nurses to ask the possibility of hospitals being responsible for travelling expenses of representatives to instructors' meetings in their particular place of meeting.

3. That, when course outlines were standardized and brought into uniformity for mimeographing, three copies be sent to each instructor to be returned in one year's time with suggestions and comments on same.

A symposium regarding licensing and R.N. examinations was given. Those taking part in this symposium were Misses I. Johnson, Rita Ball, June Stewart, E. Bietsch. This symposium proved to be very interesting and from it evolved considerable discussion.

Miss Deane-Freeman, chairman of the Public Health Section, reported on that meeting. The following recommendations were presented:

1. Whereas public health nurses in rural health units are without professional nursing guidance, that it should be requested that the Department of Public Health appoint a nurse adviser to coordinate the work of the public health nurses in these units and give them guidance.

2. Whereas industrial nursing is closely related to public health nursing, it would be advantageous for the industrial nurses to become the sub-committee of the Public Health Committee. It was recommended that action be taken for the formation of a sub-committee of industrial nurses within the framework of the Public Health Committee.

The report of the students' meeting was given by Miss Doris Bohme. Miss Smith acted as counsellor for the meeting. Miss Bohme reported that students present had toured Banff Mineral Springs Hospital and had viewed the laboratory, chapel, mineral baths, and physiotherapy and x-ray units. Wax baths were of great interest to many. Dr. D. Robertson at the hospital gave interesting case reports on arthritic and rheumatic patients. Miss Smith spoke to the students on long-term illnesses. Appreciation was expressed to the A.A.R.N. for arranging the meeting which proved to be of great value to those in attendance. The students felt that much information could be taken back to their respective hospitals.

Miss Jessie Morrison, as chairman of the Resolutions Committee, presented the following resolutions which were approved by the general meeting.

1. WHEREAS, It was suggested by the C.N.A. Guide that Private Duty Registries work toward the establishment of uniform constitution and by-laws; therefore be it *Resolved*, That the Private Duty Registry office be located in a central business area.

2. WHEREAS, Refresher courses for private duty nurses have been successfully conducted during the year 1951; therefore be it

Resolved, That the Department of Extension, University of Alberta, be approached to provide assistance for a similar program in 1952.

3. WHEREAS, It is recommended that the tariff of professional fees be uniform throughout the province, therefore be it

Some of the A.A.R.N. Executive—from left to right (front row): MRS. CLARA VAN DUSEN, Edmonton, provincial registrar; MISS F. FERGUSON, president, and SISTER L. MONGRAIN, Calgary, councillor. Back row: MISS M. FITZSIMMONS, Edmonton, Public Health Section chairman; MISS J. MORRISON, Edmonton, secretary; MISS H. PENHALE, Edmonton, first vice-president; MISS E. BIETSCH, Edmonton, second vice-president.

Resolved, That the following schedule be adopted:

8-hour duty in homes and hospitals
$8.00 per day

12-hour duty, homes only
$12.00 per day

24-hour duty, homes only
$15.00 per day

2 patients, whether or not in the same family
$6.00 per day per patient

Alcoholics or mentally-ill patients (8 hours)
$10.00 per day

Alcoholics or mentally-ill patients (12 hrs.)
$14.00 per day

Non-registered nurses (8-hour duty)
$7.00 per day

Hourly nursing in homes
$2.00 per hour

4. WHEREAS, Private duty registry fees vary considerably within the province; therefore be it

Resolved, That a uniform annual fee of $25 be assessed and the fee for 31 days of employment during the year, consecutively or intermittently, be assessed at $10.

5. WHEREAS, As a well planned orientation and evaluation program for private duty nurses assists the nurse in adjusting to new situations; therefore be it

Resolved, That such a program be initiated by all private duty registries within the province.

The following officers were elected: President, Miss J. F. Ferguson; first vice-president, Miss Helen Penhale; second vice-president, Miss Elizabeth Bietsch; councillor, Sister Mongrain; chairman, Institutional Nursing Committee, Miss J. Monteith, Lethbridge; chairman, Public Health Committee, Miss Marguerite Fitzsimmons, Edmonton; chairman, Private Duty Committee, Mrs. L. P. Garrott, Medicine Hat.

CLARA VAN DUSEN
Registrar.

Annual Meeting in Nova Scotia

The Registered Nurses' Association of Nova Scotia met at the Payzant Memorial Hospital, Windsor, for its 42nd annual meeting. Approximately 134 registered nurses were present and 13 student nurses from various hospitals throughout the province.

Rev. Roy Phillips, rector of Christ Church, gave the invocation. Mayor W. D. Morton, on

behalf of the town, welcomed the nurses. Miss M. K. Miller, Halifax, presided and in her address welcomed Miss Gertrude Hall, general secretary, Canadian Nurses' Association.

It was reported by the executive that the Grace Maternity Hospital at Halifax is formulating plans for a three-year course in general nursing to replace the 18-month course now being given. They have also requested affiliations with general and special hospitals.

The Educational Policy Committee submitted a proposed minimum curriculum for Nova Scotia which was accepted and will be sent to all schools of nursing throughout the province.

Among amendments to by-laws included an increase of $5.00 in fees for registration in 1952, which now makes the registration fee in Nova Scotia for nurses $10. The reciprocal registration fee was increased from $10 to $20 per year.

Qualifying examinations for student nurses will go into effect in October for students admitted for training on and after January 1, 1951.

An afternoon tea at the home of Mrs. H. E. Kendall and a drive through the Valley was part of the afternoon's program. In the evening a banquet was held at the Trinity Church when Miss Hall spoke on the national and international associations and the relation of the provincial associations to them.

On behalf of the association, Miss Marion Haliburton presented a life membership scroll to Miss Catherine Graham, a charter member and pioneer in organizing the Registered Nurses' Association in Nova Scotia. A bouquet of roses was presented to Miss Graham by Miss Jean MacLean of the Halifax Branch.

Special appreciation was expressed to Miss Rhoda MacDonald, superintendent of the P.M.H., and Miss Doris Redmond, for all their work towards making the association meeting such a success.

The officers for the new year are: President, Miss Kathleen Harvey, superintendent of nurses, Roseway Hospital, Shelburne; first vice-president, Miss Jean Forbes, Halifax; second vice-president, Mrs. Dorothy McKeown, Halifax; third vice-president, Sister Catherine Gerard, Halifax; secretary-treasurer, Miss Dorothy Gill.

Chairmen of Committees: Public Health, Miss Phyllis Lyttle; Institutional Nursing, Sister Marion Estelle; Private Nursing, Mrs. Jane Watkins; Public Relations, Mrs. Helen Stacey; Legislative, Miss Electa MacLennan; Educational Policy, Miss Lillian Grady; Registrar's Adviser, Miss Jean Church.

Mrs. Dorothy McKeown, on behalf of the association, expressed appreciation of the work done by Miss Miller during her three years as president. Among accomplishments noted are: the revision of the Act and by-laws, completion of the proposed curriculum, the institution of first-year qualifying examinations for nurses, and presentation of the first life membership.

The next annual meeting will be held at Liverpool on invitation from the Queens-Shelburne Branch.

NANCY H. WATSON
Secretary-Registrar.

Annual Meeting in Quebec

The 31st annual meeting of The Association of Nurses of the Province of Quebec was held in the new nurses' residence of the Hôtel-Dieu, Montreal, May 21-23, 1951. The president, Mlle Annonciade Martineau, was in the chair. The registration desk was in charge of Mlle Emma Rocque and Miss Kathleen Dickson, and the total registration was 743. *The Canadian Nurse* table, presided over by Miss Merle Smith and Mlle Octavie Préfontaine and several assistants, featured an unusually fine exhibit of pins and medals from various schools of nursing in Canada and other countries. This was a focal point of attraction throughout the convention.

Annual meetings of interest groups, English and French, were held on the evening of May 21. Excellent programs were conducted, including the following: *English groups* — an address on "General Adaptation Syndrome" by Dr. Hans Selyé, to the Institutional Nursing Committee; "Rehabilitation of the Tuberculosis Patient" by Dr. A. D. Temple, to the Public Health Nursing Committee; "Psychiatric Aspects of Endocrinopathies" by Dr. Robert Cleghorn, to the interest group on Private Nursing. *French Groups* — "Neurologie et Neurochirurgie" by Dr. André Parenteau, to the Institutional and Private Nursing members, with an accompanying de-

monstration by Miss A. Major and Mlle S. Langevin; "L'Hygiène Mentale et Facteurs Sociaux" by Dr. Paul Larivière, to the nurses of the Public Health Nursing group. A program for French-language student nurses was held on the same evening, under the chairmanship of Mlle S. Giroux.

On the evening of May 22, the French-language members attended a very interesting forum discussion on the timely subject — "Budget." Participants in the forum, which was chaired by Mlle Geneviève Lamarre, were: Mr. J. M. Morin, Mr. M. Duhamel, Mlle Brigitte Laliberté, Mr. F. A. Anger. An English-language program presented an excellent discussion of "The Role of the Nurse in the Changing World" by Mrs. Genevieve Pembroke and Miss Isobel Black.

The Bilingual Division of Industrial Nurses, on the evening of May 23, enjoyed an address by Mr. H. L. McEvoy, upon the topic "Trends and Opportunities in Industrial Nursing from Management's Point of View." During the afternoon session of the same day, Brig. J. Guy Gauvreau spoke in English and in French upon the subject "Civil Defence Planning."

A point of major importance discussed during the business sessions was the proposal to increase the annual fee for practising members from $6.00 to $10.00, as of January 1, 1952. A majority of the official delegates voted in favor of this increase.

The following officers were elected for the year 1951-52: Mlle Annonciade Martineau, president; Sr. M. Felicitas, first vice-president (English); Sr. St-Ferdinand, first vice-president (French); Miss Helene Lamont, second vice-president (English); Mlle Jacqueline Gagnon, second vice-president (French); Mlle Gabrielle Charbonneau, honorary secretary; Miss Isobel Black, honorary treasurer; Mlles Colette Julien, Cécile Demers, Lauréanne Couet, Françoise St-Pierre, Miss Vera Graham, councillors.

The Arrangements Committee for the meeting was under the co-chairmanship of Mrs. Stuart Townsend and Mlle Gabrielle Côté.

MARGARET M. STREET
Secretary-Registrar.

The King Studio, Vancouver

MARGARET M. STREET

In This Fiftieth Year, 1900-50 — Golden Jubilee Souvenir Book, St. Joseph's School of Nursing, Victoria, B.C., by Sister Mary Gregory, S.S.A. 72 pages, bound in red and gold. Illustrated. *Copies available at the School of Nursing.* Price $2.00.

This charming history is of interest to all readers but particularly to graduates of St. Joseph's School of Nursing in Victoria. Covering a span of 50 years, it commemorates the achievements of alumnae graduates as well as the progress of the School. Illustrations are varied, touching on the various phases of social and professional growth, portraying the higher moments and the ideals of an institution rich in tradition yet modern in outlook and structure.

The names of graduates from 1900 to 1950 are included as well as a portrait gallery, recalling members of the faculty and medical profession.

Surgical removal of tonsils, abscessed teeth, or other disposable or expendable organs or processes, offers very little or very limited protection against disease. Organisms can enter the body through the respiratory tract, skin, or gastrointestinal system as well as through wounds and other portals. Statistics show that the tendency to rheumatism, nephritis, heart disease, arthritis, colitis or neuritis is not reduced by tonsillectomy.

— J. EDWARD JOHNSON, M.D.

Student Nurses

Duodenal Ulcer

ANNE BAIN

Average reading time — 3 min. 36 sec.

MRS. MOORE, a middle-aged housewife, was admitted to hospital complaining of a feeling of weakness and epigastric distress. She appeared apprehensive and anemic. Laboratory reports revealed that her erythrocyte count was 3,910,000 per cu. mm. of blood, the cells showing a slight anisocytosis (i.e., distorted in size). There were 10,800 leukocytes per cu.mm. of blood which is a slight increase over the normal number of 5,000-9,000. These cells were chiefly of the small mature type.

The interne was told that Mrs. Moore first began having epigastric pain about 30 years ago. These pains would awaken her regularly at about 2:30 a.m. and were occasionally accompanied by nausea and vomiting. The pain was relieved by taking soda bicarbonate. Seven years later she had a massive gastrointestinal hemorrhage. At that time an x-ray of the stomach and duodenum revealed a duodenal ulcer. Her diet was regulated at that time according to ulcer diet standards but, since then, she has had recurrent episodes of gastric hemorrhage, each one being severe enough to require that she be given a blood transfusion following the attack. Between these hemorrhages her appetite has been good and no weight has been lost.

History revealed that three other members of her immediate family had duodenal ulcers and that two of these had perforated. Her mother died of carcinoma of the stomach.

Fractional gastric analysis showed blood present in every specimen. The total acidity curve and free hydrochloric acid curve showed irregularities with periods of hyperacidity. Normally the total acidity should reach a high of 60; free hydrochloric should reach a high of 40 at 1-1¼ hours. The feces were black and tarry which was suggestive of bleeding high up in the gastrointestinal tract—possibly from the stomach or duodenum. Diagnosis was established as "chronic duodenal ulcer" and surgery was advised since the ulcer was so long-standing and had not responded to medical treatment.

The surgical pathology report on the stomach tissue removed at the time of the operation revealed evidence of hypertrophic changes in the mucosa and in the pyloric region of the stomach. In the duodenum there was some evidence of superficial ulceration and slight erosion of the surface epithelium at several points.

Following surgery the symptoms of the patient were relieved and she made an unusually rapid recovery.

I found that nursing this patient roused me to recall the textbook pictures of duodenal ulcer and the differences between duodenal and gastric ulcer. Some of these points are:

The cause of peptic ulcer is unknown. The modern theory is that psychic or physical stimulation of vagus nerve impulses causes increased gastric motility, hypersecretion, hyperchlorhydria, and vasospasm leading to infarctions and erosions of the mucosa.

The pain of peptic ulcers is due to the irritation of the hydrochloric acid. Food or alkalis (such as soda bicarbonate) neutralize the acid, giving the patient relief. Vomiting and hematemesis frequently occur. Diagnosis may be made

Miss Bain is a student nurse at Victoria Hospital, London, Ont.

by history, physical examination, barium meal followed by x-ray, and gastric analysis.

Although peptic ulcer is usually a chronic disease, the ulcer may develop and heal rapidly. Peptic ulcers show a major and minor periodicity. Major periodicity means that pain and perforation are more prominent in spring and fall and minor periodicity refers to the usual sequence of pain-food-relief.

Duodenal ulcer is rarely associated with cancer as the high acid secretion seems to protect it but gastric carcinoma is a complication of gastric ulcer in 7 per cent of cases.

Book Reviews

Nursing Service Research — Experimental Studies with the Nursing Service Team, by Viola Constance Bredenberg, M.S. 170 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1951. Price $5.75.

Reviewed by Elizabeth Braund, formerly Placement Adviser, Registered Nurses' Association of British Columbia.

"Nursing Service Research" contains the findings of a one-year study conducted by Miss Bredenberg in the School of Nursing Education, The Catholic University of America, Washington. The research deals with the hours of nursing per patient, the ratio of professional to non-professional nurses in the nursing-care team, a functional analysis to determine a distribution of nursing activities among various levels of workers, the improvement of qualitative and quantative nursing care, the development of a sound clinical situation for the teaching of student nurses, and the development of standards which could be applied generally.

Each phase of the study is carefully described. Charts, graphs and assignment outlines are freely used and add to the clarity of the material. More than half of the book consists of bibliography and appendices. These are excellent reference material.

Nurses who are confronted with the problem of utilizing professional and non-professional staff to a maximum advantage and of maintaining a high standard of nursing care will welcome the findings on the nursing care team and ward clerks. Because, with the minimum of adaptation, similar research could be carried out in other hospitals, directors of nursing and head nurses should find this book very useful.

America's Baby Book — prepared under the auspices of *The New York Herald Tribune* Home Institute, by John C. Montgomery, M.D., and Margaret Jane Suydam. 457 pages. Published in Canada by S. J. Reginald Saunders & Co. Ltd., 84 Wellington St. W., Toronto 1. 1951. Illustrated. Price $3.98.

Reviewed by Eleanor Atkins, Clinical Supervisor, Infant Wards, Hospital for Sick Children, Toronto.

This book presents a complete and authoritative guide to infant and child care — from the prenatal period through to six years of age. It makes one aware that each child is an individual with definite characteristics making him differ from any other child. It points out, too, that every child "from the moment of birth has emotional, social, intellectual, and spiritual needs that are of equal importance with his physical needs."

Through the many stages of growth and development both parents are given valuable help in meeting these needs of their child. These details are given clearly and convincingly; all topics are dealt with from a practical and common sense point of view. The natural illustrations depicting actual situations make it a most attractive book for either a beginner or an experienced reader.

The suggested help to mothers in the chapters on home management, plus the additional wealth of facts supplied in the appendices on play materials, food, and homemaking, should all tend to lighten the load of a mother's 24-hour duty.

This book can be used advantageously by nurses in whose care children of this age group are placed. It emphasizes the need for supplying emotional security, so often overlooked

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Further information may be obtained from the *Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria.*

Candidates must be British Subjects under 40 years of age, except in the case of ex-service women who are given preference, unmarried, or self-supporting. Application forms obtainable from all *Government Agencies, the Civil Service Commission, Weiler Bldg., Victoria,* or *636 Burrard St., Vancouver,* to be completed and returned to the **Chairman, Victoria.**

THE ASSOCIATION OF NURSES of the PROVINCE OF QUEBEC

The 1951 Fall Examinations for Provincial Registration will cover two groups of candidates and will be held as follows:

EXAMINATIONS FOR REGISTRATION —Part II: Graduates desiring to qualify for a licence to practise will write on **November 19, 20 and 21, 1951.** Candidates will not be permitted to write these examinations until they have actually completed their training and hold the diploma of their school. *Applications must be received by October 19, 1951.*

EXAMINATIONS FOR REGISTRATION Part I: Students who will have completed their first year will enter the Examinations for Registration, Part I, which will be held on **October 15, 16 and 17, 1951.** (Time to be announced in each school.) *Applications must be received by Sept. 15, 1951.*

For application forms and all information relating to the examinations, apply to the headquarters of the Association.

MARGARET M. STREET, R.N.
Secretary-Registrar
Ste. 506 — 1538 Sherbrooke St. W.
Montreal 25, Que.

by nurses in their busy daily hospital routine. The author's comment that mothers, if possible, should stay in hospital with their children under three years of age is interesting.

This book can be of valuable assistance to young parents in answering many of the innumerable questions which arise in their minds regarding their child and help them "to guide him in a kindly, friendly, firm and affectionate manner."

Achieving Maturity, by Jane Warters. 349 pages. Published by McGraw-Hill Co. of Canada Ltd., 50 York St., Toronto 1. 1949. Price $3.65.

Reviewed by Margaret E. Hart, Director, School of Nursing Education, University of Manitoba.

The author, who is director of personnel at State Teachers College, Lock Haven, Pa., states in the preface of her book that her purpose is to present the results of recent studies on adolescence in such a way that young people may be helped to understand and meet the problems which face them as they grow into maturity.

A very personal approach has been used in chapter headings, each one being directed to the young person reading the book. Typical questions are raised which the adolescent may be expected to have in relation to his everyday experiences in living. The ordinary pattern of growth and maturation which each adolescent may regard as peculiar to himself is thus described. Studies on health and growth, personality, marriage, school and vocation have been used as a foundation for discussion and conclusions.

The book is intended for use in senior high school and college and much of the material appears suitable for this age group. The language used in parts of the book would have more meaning for the student who has had some introduction to the fields of psychology and guidance.

References range from those which are suitable for the student to those which the experienced and well qualified teacher or nurse would find helpful. Many of the books listed have been in common use by those responsible for guidance of adolescents and youth.

The first half of the book describes the basic needs which each person must be able to satisfy in some degree at least, if he is to develop a wholesome personality. The second part describes some of the ways in which the individual responds when obstacles

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block the way to satisfaction of these needs. Frustration and inferiority are described as feelings which are common to adolescents, as are some of the adjustments which are employed to overcome these feelings. The author indicates the relative maturity of response to frustrations which is made as the child grows and develops. Discussion of the more negative aspects of behavior is developed in a constructive way. The last few chapters are devoted to vocational and educational guidance of the student.

This book is a valuable addition to the reference material which nurses have found useful in health guidance of individuals and groups of this age. It would also be a helpful guide to the nurse in her work with adults who in turn are responsible for guidance of adolescents and youth.

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Application forms may be obtained from the **Nova Scotia Civil Service Commission, Box 943, Halifax, Nova Scotia.** *Phone 3-7341, Branch 230.*

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In Memoriam

Edith Rosella (MacDonald) Benjamin, who graduated from the Hospital for Sick Children, Toronto, in 1928, died in Windsor, Ont., on June 30, 1951, at the age of 46, following a year-long illness.

* * *

Isabelle Laidlaw, an early graduate of the Hamilton General Hospital, Ont., died in Hamilton on July 9, 1951, after an illness of several weeks. Miss Laidlaw had been very active in private duty until her retirement.

* * *

Glennie Mayhew, who graduated from Jeffery Hale's Hospital, Quebec, died on June 18, 1951. Miss Mayhew served overseas for four years during World War I.

* * *

Frances Owen McEwan, who graduated from the Montreal General Hospital in 1896, died in California on May 4, 1951, in her 90th year.

* * *

Dorothy (Andrews) Niles, a graduate of Saint John General Hospital, N.B., died recently in Woodstock, N.B.

* * *

Josephine Pierson, a graduate of the Guelph General Hospital, Ont., died there on May 24, 1951. For almost 30 years Miss Pierson worked at G.G.H. She retired some five years ago.

* * *

Lucy Sanders died in New Westminster, B.C., on July 4, 1951, following a long illness. Born in Ontario, Miss Sanders graduated from Mount Sinai Hospital, New York. She served overseas during World War I. Returning to Canada, she was assistant superintendent of nurses at the Winnipeg General Hospital, then at the Royal Alexandra Hospital, Edmonton. She was director of nurses at the Powell River (B.C.) Hospital, later going to a similar position at the Ladysmith Hospital. In 1936 she became night supervisor of the Royal Columbian Hospital, New

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Westminster. For two years prior to her retirement in 1950 she was assistant director of nurses there.

* * *

Georgina M. Sangster, who graduated from Victoria Hospital, London, in 1917, died there on July 21, 1951. Miss Sangster was on the staff of Westminster Hospital, London, for many years.

* * *

Marjorie Taylor, aged 23, who graduated from the Misericordia Hospital, Edmonton, in 1950, died on June 27, 1951, from injuries suffered in a car accident.

Nursing Sisters' Association

The following officers are serving on the executive of the *London Unit*: President, Marjorie Rutherford; vice-presidents, Edna (Covert) Glover, Reta Nicely; secretary, Miss Meek; treasurer, K. Unger; representative to Local Council of Women, Mrs. Reg Martin; additional executive, Mmes May Moran, H. Cervie. The past president is Della Birrell.

A successful bridge netted proceeds for charitable work. Plans are being made for the 25th anniversary of the association to be held in November.

Victorian Order of Nurses

The following are recent staff changes in the Victorian Order of Nurses for Canada.

Appointments — Barrie, Ont.: *Lorraine Somerville* (Ottawa Civic Hosp. and University of Toronto) as nurse in charge. Burnaby, B.C.: *Vivian Wylie* (Royal Jubilee Hosp., Victoria, and University of British Columbia). Collingwood, Ont.: *Doris Arrand* (Victoria Hosp., London, Ont. and University of Western Ont.) as nurse in charge. Fort William, Ont.: *Mrs. Margery Rutherford* (Port Arthur Gen. Hosp. and U. of T.). Halifax: *Jean Lewis* (Hosp. for Sick Children, Toronto, and Dalhousie University, Halifax). Hamilton, Ont.: *Helen Taylor* (Hamilton Gen. Hosp.) and *Mrs. Catherine Wolczek* (Royal Infirmary,

SURGICAL NURSING

By Robert K. Felter, Frances West, and Lydia M. Zetzsche. This new, radically revised edition contains new units in Orthopedics and Surgery of the Eye, Ear, Nose and Throat. 308 illustrations, 710 pages, fifth edition, 1950. $4.75.

MEDICAL NURSING

By Edgar Hull and Cecilia M. Perrodin. Medical advances, nursing advances and teaching advances are reflected in this new edition. New material covers skin diseases (two new chapters), diseases of the nose, mouth and throat, infectious diseases. 844 pages, 172 illustrations, fourth edition, 1950. $4.75.

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Perth, Scotland). Kingston, Ont.: *Margaret Donevan* (Kingston Gen. Hosp. and Queen's University, Kingston). Leamington, Ont.: *Joyce Webster* (Winnipeg Gen. Hosp. and McGill University) as nurse in charge. London, Ont.: *Dorothy Tolboom* (Victoria Hosp., London, and U.W.O.). Montreal: *Elizabeth McPhedran* (Winnipeg Gen. Hosp.). Orillia, Ont.: *Ada McEwen* (Montreal Gen. Hosp. and McGill U.) as nurse in charge. Oshawa, Ont.: *Edythe Young* (Oshawa Gen. Hosp. and U. of T.). Ottawa: *Mrs. Mary Barnes* (H.S.C., Toronto), *Mrs. Frances Brown* (Royal Victoria Hosp., Montreal), and *Elizabeth Surtees* (Gen. Hosp., Carlisle, Eng., and Royal Sanitary Institute for Scotland). Owen Sound, Ont.: *Helen Brunkard* (Kitchener & Waterloo Hosp. and U. of T.). Sarnia, Ont.: *Mrs Edna McDougall* (Sarnia Gen. Hosp.). Sudbury, Ont.: *Helen Minaker* (Oshawa Gen. Hosp. and U. of T.). Sydney, N.S.: *Mrs. Jessie Dougall* (Glace Bay Gen. Hosp., N.S. and U. of T.). Toronto: *Thora Gerow* (Belleville Gen. Hosp., Ont. and U. of T.) and *Ethel Jean Gordon-Figgins* (U. of T.). Vancouver: *Elizabeth Graham* (R.V.H., Montreal). Victoria: *Dorothy Parfitt* (Vancouver Gen. Hosp.). Windsor, Ont.: *Barbara Austin* and *Georgina Folean* (Metropolitan School of Nursing, Windsor, and U. of T.). Winnipeg: *Mrs. Edna Haussler* (St. Michael's Hosp., Toronto, and Queen's U.), *Beryl Marsland* (W.G.H.), and *Frances McKenzie* (R.J.H., Victoria, and University of Manitoba). York Township: *Mrs. Elizabeth Terry* (Ont. Hosp., New Toronto).

Transfer — *Winnifred James* from Truro, N.S., as nurse in charge, to Chatham, Ont., staff.

Leave of absence—*Joy Clarke* from Barrie.

Resignations — Brampton, Ont.: *Heather Matthew* as nurse in charge. Lachine, Que.: *Gisèle Lanctot*. Montreal: *Mrs. E. C. Laidlaw*. North York, Ont.: *Ruth Walbridge*. Owen Sound: *Mrs. Donna Ward*. Pt. Claire, Que.: *Claire Doucet* as nurse in charge. Saint John, N.B.: *Charlotte Myles*. Sydney: *Mrs. F. Fortune*. Timmins, Ont.: *Mrs. Eleanor Campbell* as nurse in charge. Toronto: *Margaret Anderson, Everil Jean Eade, Bernadette Hill, Margaret Marshall, Edna Stephenson, Joyce Tyrrell*. Winnipeg: *Katherine McDonald*.

M.L.I.C. Nursing Service

Brigitte Beaudet and *Bernadette Tessier* have completed the public health nursing course

at the University of Montreal and have been reappointed to the Montreal staff of the Metropolitan Life Insurance Co. nursing service. *Mariette Leger*, of the Quebec City staff, has resigned to be married.

News Notes

ALBERTA

TABER

Helen Clemis, matron of the Municipal Hospital here since November, 1949, has left Taber to accept a similar position at Crowsnest Pass Municipal Hospital at Blairmore, Miss Clemis, a native of Lethbridge, came to Taber from Raymond. Flossy Watkins, a graduate of Royal Alexandra Hospital, Edmonton, will replace Miss Clemis. She has served at her home hospital as supervisor and has also been employed in Medicine Hat.

MANITOBA

BRANDON

General Hospital

Fifteen nurses received their caps at an impressive ceremony held at St. Mary's Anglican Church. Those taking part included: prelude, D. Wisdahl; invocation, Canon H. L. Newton; presentation of candidates, Mrs. L. Moir, nursing arts instructor; capping, M. Jackson, superintendent of nurses, and P. Donohoe, science instructor; welcome, E. MacKenzie, president, Student Body; response, D. Belous.

I. Lightley was guest of honor at a tea in the nurses' residence when she was presented with a gift from members of the staff from which she has resigned. Previous to this, Miss Lightley had received a gift from the student body in appreciation of her work. Jean Harding and Jean Higgens have returned from the University of Western Ontario where they had taken the course in teaching and supervision in schools of nursing. They are now on the teaching department staff.

NEW BRUNSWICK

WOODSTOCK

Nursing Sister Marian F. Neily, a graduate of L. P. Fisher Memorial Hospital, and a native of Spa Springs, N.S., is a member of the first class of R.C.A.F. nurses to undergo parachute training. Miss Neily served as staff nurse with a Black's Harbor, N.B., firm, for a year, enlisting with the air force in February.

NOVA SCOTIA

HALIFAX

Victoria General Hospital

The alumnae association recently held a

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delightful tea at the nurses' residence when Mrs. T. Carpenter, president, and Catherine Graham received the guests. The tea table was presided over by Maisie Miller, director of nurses, and Laura Hubley, Sadie Archard, and Laura Paige. The occasion of the tea was to honor three senior alumnae members: Catherine Graham, retired city health nurse, was made a life member of the association and presented with a suitably engraved scroll and a corsage of roses — presentation was made by Mrs. Carpenter; Margaret MacKenzie, retired superintendent of public health nurses for Nova Scotia; Jane Hubley, retired assistant superintendent of nurses, Dalhousie Public Health Clinic. Misses MacKenzie and Hubley received a book and corsage of carnations. Presentations were made by Mrs. H. S. T. Williams, alumnae vice-president, and Mrs. J. Cameron, retiring president. Mrs. W. Hunt was convener for this event.

ONTARIO

District 1

Windsor

Mrs. Mae Creighton has been appointed as the new director of nursing services of the Windsor branch of the Canadian Red Cross. Mrs. Creighton succeeds Mrs. B. DeRychere who has been serving as temporary nursing services supervisor for the past six months, following the resignation of Betty Martin.

Districts 2 and 3

Owen Sound

Alma Patterson is on duty at the General and Marine Hospital as assistant to the director of nursing, W. Cooke. A graduate of the Brantford General Hospital, Miss Patterson has taken post-graduate courses at the University of Toronto School of Nursing and the Weston Sanatorium. She has had ten years' experience at Listowel (Ont.) Memorial Hospital and two years with the South African Nursing Service during World War II.

District 4

Niagara Falls

Wilhelmine A. H. Twidale, a former public health nurse in this city, has been appointed to the New Jersey State Board of Nursing. Miss Twidale was at one time assistant supervisor at the St. Catharines General Hospital.

District 8

Ottawa Civic Hospital

Florence Cameron, a 1944 graduate and a native of Cornwall, has joined the R.C.A.F. as a nursing sister, stationed at Rockliffe. She has been on the nursing staff of Hotel Dieu, Cornwall, for the past year.

QUEBEC

Montreal

Children's Memorial Hospital

The following are now on the staff: assistant

O. R. supervisor, E. Bauer; O.R., C. Mathews, M. Quilty; O.P.D., R. Currie, E. O'Brien, Mrs. M. Murphy; senior rotation, E. Braithwaite; junior rotation, W. Banas, B. Brock. E. Collins is now head nurse, Ward H, M. McKenney, head nurse on Ward L. Miss Tallon, Mrs. (Gribben) Cassidy, and Mrs. (Russell) Buchanan have returned to the staff. J. Cochrane, O.P.D. supervisor for several years, has left to be married. She will be residing in Montreal. The following have resigned: Misses Ellis (to be married), Myra, McMullin, E. Black, and Mrs. Woolner.

Royal Victoria Hospital

The following staff changes have recently taken place in the main building: Ward A, N. Calder, assistant head nurse, has left to be married, and is replaced by D. Leslie; Ward D, R. Murray, assistant; Ward F, J. Baird is engaged in post-graduate study at London, Ont.; Ward G, B. Colpitts has replaced Miss Boyd as head nurse, with L. Rosevear as assistant; Ward M, Miss Eves is head nurse assisted by E. Turner; R. Leriche is assistant night supervisor. M. Barrett is medical supervisor. M. Darville has retired from the nurses' homes after many years of service in the infirmary. J. McGregor is a new member of the teaching department, replacing B. Allan who resigned.

SASKATCHEWAN

HUMBOLDT

In May, the Humboldt Chapter held a successful formal dance.

Ten graduates of St. Elizabeth's Hospital School of Nursing received their diplomas at the ceremonies held in June. Ruby Tinkiss, Division of Maternal and Child Hygiene, Department of National Health and Welfare, conducted a series of lectures and discussions on child welfare at the hospital. Her program also included a number of films. Thelma Bloor, of the O.R. staff, is in B.C. taking a post-graduate course in surgery. Congratulations are extended to Sr. Marcella who won the prize for the best article at the x-ray convention held in Regina in May.

REGINA

General Hospital

At an impressive candlelighting ceremony held in July, 34 nursing students had their caps presented to them by M. E. Thompson, superintendent of nurses. During the ceremony Grayce Mackintosh, a junior student, sang "The Lord's Prayer," accompanied by S. Larson at the piano. Lola Wilson, S.R.N.A. registrar, and Ruth Kennedy, nursing supervisor, presided at the tea table. Guests included mothers and friends of the students.

Grey Nuns' Hospital

Seventy-seven nurses, the largest class in the history of the School of Nursing, received their diplomas at the exercises held in April.

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Twelve prizes for nursing proficiency were awarded as well as two scholarships from the alumnae and the Catholic Nurses' Association. Memorial Day was observed on May 6 by the Catholic nurses in the Grey Nuns' Chapel and by the Protestant nurses at Knox United Church. Hazel Keeler, school of nursing adviser for the province, paid an official visit to the school in May.

F. Gibson (obstetrics) and M. Howell (health nurse) are leaving the staff to be married while Mrs. N. Street (instructor) will take up new work in Halifax. Joyce Courtenay will be the new health nurse for the school. Formerly on the general duty staff, D. Vennard, of Radville, is now a stewardess with T.C.A., based in Toronto.

Plans to inaugurate occupational therapy for the patients are underway, under the auspices of the Lady Patronesses of the hospital.

SASKATOON

Over 300 nurses from the public health department, Saskatoon Sanatorium, St. Paul's and City hospitals celebrated Memorial Day by a church parade in uniform. The choir was composed of Glee Club members from the two hospitals.

City Hospital

Nearly 300 graduates from all parts of Canada and the U.S.A. registered for the 40th anniversary of the alumnae association on June 11, 12, and 13. Activities for the first day of the reunion included a tour of the nurses' new residence (funds for furnishing the kitchens are being raised by the alumnae) followed by a luncheon given by the hospital. Dr. G. M. T. Hazen, chief of medical staff, addressed the members at a dinner in the evening held at Bessborough Hotel. A revue, showing changes in nurses' uniforms since 1911, was the highlight of the luncheon held on the 12th. In the evening, the president, Mrs. J. Tait, was hostess at a coffee party. The following day a tour was made of the Medical Building and the University hospital. Dr. R. O. and Mrs. Hodgson later entertained at tea.

The highlight of the reunion was the graduation exercises of the School of Nursing when 63 nurses received their pins and diplomas. Mrs. J. E. Porteous, former director of nursing at the hospital, who now holds a similar position at the Greater Niagara General Hospital, Niagara Falls, attended, at the request of the class, to present the pins. The address was given by Dr. C. B. Orchard. Award winners included: L. Bowerman, H. Bowes, M. Davidson, J. Gibson, J. Jones, L. Kangas, I. Rampton, M. Warkentin. Following the exercises, friends and relatives were among the guests at the reception at *H.M.C.S. Unicorn*. Honors at the tea table were performed by: Mmes F. H. Williams, P. Reynolds, M. R. Tait, C. B. Orchard, H. F. Wilson, G. Fenty, G. M. G. Hazen, and Miss H. Keeler. During graduation week other highlights included: a wiener roast, theatre party, banquet and graduation dance, and numerous teas.

Positions on the teaching staff have been accepted by Mrs. A. Osiowy (St. Boniface Hospital, Man., and University of Minnesota) as educational and social director, and by P. Sharp (S.C.H. and University of Saskatchewan) as science instructor. Mrs. V. (Clark) Price is another new staff member. G. James, former educational and social director, has accepted a W. K. Kellogg Scholarship for further study at Columbia University.

C. Caswell, who has been on leave of absence for study at the University of Toronto, received honors in her course in teaching and supervision in O.R. technique and has resumed her duties in the O.R.

St. Paul's Hospital

In July, the February, 1951, students received their caps and entertained the Reverend Fathers and Sisters, families and friends at a delightful concert and "capping party."

S. Clark, "2A" Student Council, president and M. Mooney, "2A," went as delegates of the Student Council to the S.R.N.A. convention held in Regina in May. T. Clarkson ("2A"), representing the Sodality, was invited to attend the annual meeting of the S.C.C.N. in Regina. All three students gave informative reports on their return. R. O'Byrne ("2B"), president, St. Paul's Sodality, attended the fourth annual Dandelion Vacation College held at the Banff School of Fine Arts in June. Sr. Bezaire, superior, and Sr. Viens attended the hospital administration institute held at the University of Alberta.

Sr. Sauve, after 15 years of devoted service at St. Paul's, is now on duty at Cardston Hospital, Alta. Sr. Fortin has left after 11 years of faithful service as supervisor, purchasing department. A welcome is extended to Srs. Leclerc and Gauthier. Other new staff members include: M. Cook, D. Haugen, and G. Johnston, clinical instructors; E. Fedoruk, clinical supervisor in pediatrics. Mrs. I. Redston, clinical instructor, has left for Regina.

During her visit from Beauval, Sr. A. Mageau greatly enriched the residence by the gift of a talented work of art depicting a mountain scene, which now adorns the school auditorium. D. Moore and F. Cochrane from Hamilton, Ont., and Mrs. (Moker) Taylor were recent visitors to the school.

Saskatoon Sanatorium

New staff members include: G. Schuman, head nurse, surgical ward, A. MacDonald, A. Rempel, C. Solie. D. Birch and C. Felix have resigned.

BERMUDA

Eleanor E. Dixon of Calgary, Alta., Margaret Munro and Marjorie J. Rigby, both of Jamaica, received their diplomas at the graduation exercises of the King Edward VII Memorial Hospital. The graduates and Bernice Underhill, matron, were guests of honor of the alumnae association at the annual dinner when Mrs. Fred Tite, vice-president, was hostess. The guest speakers were Lady Hall and Rosemary Lamb. Lady Hall, daughter of the late Dr. Trott of Bermuda, spoke of the work being done in Bermuda for the blind. The interest of the public being aroused, braille has been introduced. Occupational therapy is next on the list. Miss Lamb comes from England and is employed by the Department of Education in the school for the deaf. Through the Red Cross, she also conducts an adult lip-reading class for the hard-of-hearing.

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Matron for 8-bed hospital now under construction. Duties to commence approx. Nov. 1. Excellent living conditions in good town. State salary & experience. Apply F. C. McMurchy, Sec., Hospital Unit, Reston, Man.

Instructor for Teaching Staff of 300-bed hospital with 50 students. **Supervisor for Obstetrical Dept.** Generous personnel practices. Apply, stating qualifications & experience, Director of Nursing, McKellar General Hospital, Fort William, Ont.

Charge Nurse for Admitting Dept. of Children's Hospital, 250 West 59th Ave., Vancouver 15, B.C., by Jan. 1952. Special qualifications or previous experience in out-patient clinics & admitting office routine necessary. Apply Director of Nursing.

Occupational Therapist (1) & Handicraft Instructor (1) for 350 bed-Tuberculosis Hospital, 60 miles north of Montreal in the Laurentians. Apply, stating full data & salary expected, Medical Director, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Graduate Nurses for General Duty (2) immediately. Salary: $175 with annual increment of $5.00. Board, $26. 44-hr. wk. 28 days holiday after 1st yr. service. Sick leave, 1½ days per mo. Fare advanced if required. Apply Matron, Slocan Community Hospital, New Denver, B.C.

General Duty Nurses for Queens General Hospital, Liverpool, Nova Scotia. New hospital. Ideal living conditions. 8-hr. day. Blue Cross available. Apply, stating qualifications & experience, to Supt.

Registered Nurses for General Duty for 20-bed Isolation Hospital. Salary: $200 per mo. Meals & laundry. 8-hr. duty. 44-hr. wk. Apply Arthur H. Evans, Sec., Board of Health, Port Arthur, Ont.

Registered Nurse for 14-bed hospital. Salary: $150 plus full maintenance. 48-hr. wk. Apply Mrs. E. Green, Matron, Memorial Hospital, Crystal City, Man.

Registered Nurse for General Duty for 22-bed hospital. Good salary. 8-hr. duty rotating shifts. 6-day wk. & living-in accommodation. 12 days sick leave. 2 wks. vacation with pay & 7 statutory holidays. Apply Supt., General Hospital, Palmerston, Ont.

General Duty Nurses for 107-bed modern hospital. Starting salary: $165 per mo. plus meals & laundry. Additional for night duty. Increases at 6 mos. & annually thereafter for further 2 yrs. 30 days holiday with pay after 1 yr. service. Travelling expenses refunded after 6 mos. from point of entry into Ont. Cumulative sick time. Medical & Hospital plans available. Apply Supt. of Nurses, Kirkland & District Hospital, Kirkland Lake, Ont.

General Staff Nurses for Union Hospital, Rosetown, Sask. Salary: $145 per mo. with full maintenance. $5.00 increase after 1 yr. to $20, a maximum in 4 years. 1 mo. holiday with pay per yr. Staff cared for in sickness as necessary. Shifts rotating with 4 wks. days, 2 wks. evenings & 2 wks. nights usually. 6-day wk. Hospital &.residence well equipped & maintained. 3 practising doctors. Apply Acting Supt. of Nurses.

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Operating Room Supervisor with post-graduate course & experience for 200-bed hospital active service. School of Nursing. Salary: $195-220. For full particulars apply Supt. of Nurses, General Hospital, Moose Jaw, Sask.

Graduate Dietitian for 200-bed hospital. Initial salary: $2,400 per annum plus full maintenance. Cumulative sick leave. Superannuation. 3 wks. vacation. Statutory holidays with pay. 44-hr. wk. Apply Sister Supt., Providence Hospital, Moose Jaw, Sask.

Public Health Nurse immediately to direct Child & Maternal Health Program for national voluntary association. Apply, stating qualifications & salary expected, Health League of Canada, 111 Avenue Rd., Toronto 5, Ont.

Public Health Nurse. Apply in writing, stating qualifications, age, experience, salary expected, etc., M.O.H., City of Owen Sound Health Dept., Ont.

Orderlies (experienced) immediately. Apply Personnel Office, St. Joseph's Hospital, Victoria, B.C.

Registered or Graduate Nurses for 40-bed hospital, 40 miles from Ottawa with good bus & train accommodations. 8-hr. day. 3 wks. holiday & 2 wks. sick leave annually. Also 7 statutory holidays. Apply Supt., Arnprior & District Memorial Hospital, Arnprior, Ont.

General Duty Nurses. Salary: $185 per mo. 44-hr. wk. 3 wks. vacation plus 8 statutory holidays. New 48-bed hospital opening soon in Dunnville, Ont. Also **Supervisors** (**3**). Salary: $200 per mo. Living accommodation arranged if desired. Write Supt., Haldimand Memorial Hospital, P.O. Box 509, Dunnville, Ont.

Registered Nurse—Floor Supervisor or General Duty Nurse interested in permanent position in pleasant surroundings in small approved sanatorium in southern Michigan city, 70 miles from Detroit. Experience in Tuberculosis Nursing desirable but not required. 40-hr. wk. Vacation & sick leave with pay. 6 paid holidays. Retirement plan. Full or partial maintenance. Minimum salary: $220 & up dependent upon ability & responsibility. Write Miss W. Miller, Supt. of Nurses, Jackson County Sanatorium, Jackson, Michigan.

Registered Nurses (**2**) for new 10-bed hospital. Salary: $150 per mo. plus full maintenance. Apply L. F. Krawchuk, Sec.-Treas., Municipal Hospital District, Glendon, Alta.

O.R. Supervisor with P.G., Scrub Nurse, Night Supervisor & General Duty Nurses for modern 100-bed hospital. Basic salaries respectively: $205, $185, $195, $175 plus present C.O.L. adjustments, $20. 44-hr. wk. 4 wks. annual vacation. Sick time. 10 statutory holidays. Apply Supt. of Nurses, General Hospital, Chilliwack, B.C.

Public Health Nurses immediately for Greater Montreal Branch, Victorian Order of Nurses. Interesting program of nursing care & health counselling in homes. Stimulating staff education program. 5-day wk. 4 wks. vacation. Initial salary: $2,160. Apply District Supt., V.O.N. 1246 Bishop St., Montreal 25, Que.

General Duty Nurses for 680-bed General Hospital with School of Nursing. Beginning salary: $255 with $10 additional for special services, p.m. & night shifts. $13 increase after 6 mos. $14 additional increase 1 yr. after 1st increase. 40-hr. wk. 11 paid holidays. 3 wks. vacation. Free laundry. Cumulative sick leave. Full maintenance if desired at $45 per mo. Apply Director of Nursing Service, General Hospital, Fresno, California.

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Graduate Floor Duty Nurses for General Hospital, Hamilton, Ont. Gross initial bi-weekly salary: $79 plus Cost of Living Bonus of approx. $3.00. 44-hr. wk. For other perquisites & further information write C. E. Brewster, Supt. of Nurses.

General Duty Nurses for Pediatrics; General, Surgical & Medical Nursing for permanent positions. For information & personnel policies write Director of Nursing, Victoria Hospital, London, Ont.

Registered Nurses for General Staff Duty on Rotation Service. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Ave., Montreal 25, Que.

Instructor of Nursing & Clinical Supervisor. Apply Director of Nursing, Victoria Public Hospital, Fredericton, N.B.

Science Instructor & Clinical Supervisor. Full maintenance. Ideal living conditions. Apply Miss C. MacCullie, Director of Nursing, General Hospital, Woodstock, Ont.

Nursing Arts Instructor & General Duty Nurses for 200-bed hospital. Salaries $195 & $175 plus Cost of Living Bonuses, respectively. 8-hr. day, 88-hr. fortnight. Statutory holidays. Sick time. 4 wks. annual vacation. Apply Supt. of Nurses, Royal Inland Hospital, Kamloops, B.C.

General Duty Nurses for 40-bed hospital. 44-hr. wk. 28 days annual vacation plus 10 statutory holidays. Annual increases & sick leave. Self-contained nurses home. Commencing salary: $185 plus $10 monthly bonus. Full maintenance, $40 per mo. Apply Administrator, General Hospital, Princeton, B.C.

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Nurse-Administrator for 30-bed hospital near Toronto, to be opened Jan. 1952. Apply, stating experience, references, salary required & date available, to Ajax & Pickering Township General Hospital, Ajax, Ont.

General Duty Nurses. Positions available in Alameda, Berkeley, Oakland, Richmond & other California East Bay cities. Nurses registered in their home states or Canada can secure temporary permits to practise nursing in California until Jan. 1, 1954, without examination. Permits may be secured by applying to the Calif. State Board of Nurse Examiners, Sacramento Calif. The following salaries & personnel practices have been established for nurses in the above area: Starting salary: $240 per mo.; $2.50 per mo. tenure increases for each 6 mos. of service to a maximum of 3 yrs. A premium of $10 per mo. paid for night & evening duty; $10 premium also paid for delivery room or operating room duty. 40-hr. wk. 2 wks. vacation for each yr. service. 3 wks. vacation for 5 yrs. service. 7 paid holidays. Sick leave cumulative to 20 work days. Blue Cross Hospital Insurance paid by hospital. For further information write directly to the Director of Nurses of one of the following hospitals: Alameda Hosp., Alameda; Albany Hosp., Albany; Alta Bates Hosp., Berkeley; Children's Hosp. of the East Bay, Oakland; Concord Hosp., Concord; East Oakland Hosp., Oakland; Herrick Memorial Hosp., Berkeley; Martinez Community Hosp., Martinez; Merritt Hosp., Oakland; Peralta Hosp., Oakland; Permanente Hosp., Oakland; Pittsburg Community Hosp., Pittsburg; Providence Hosp., Oakland; Richmond Hosp., Richmond.

General Duty Nurse for Municipal Hospital, Brooks, Alta. Situated on C.P.R. main line between Winnipeg & Vancouver. Salary: $145 & full maintenance with $5.00 increment every 6 mos. Sick leave with pay. Holidays with pay & statutory holidays each yr. 8-hr. day, 6-day wk. District noted for hunting, fishing & holiday resorts located on Trans-Canada highway. Apply Miss M. Ellis, Supt.

General Duty Nurses. Salary: $163.40 per 4 wks. 26 pays in a yr. on a bi-weekly basis. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day: 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Graduate Nurses (2) for 56-bed hospital in North-Central B.C. Basic salary for B.C. registrants: $185 gross; $44.25 deductions for full maintenance in newly constructed residence. Ample recreational facilities. Apply, giving particulars of training & experience, Miss M. Rowe, Supt. of Nurses, Wrinch Memorial Hospital, Hazelton, B.C.

Public Health Nurse (qualified). Salary according to experience. Car provided or car allowance. Desirable position close to Toronto. Apply Medical Officer of Health, York County Health Unit, Newmarket, Ont.

Industrial Nurse for large manufacturing plant near Medicine Hat. Must be qualified. Salary: $220 per mo. Pension & insurance plans available. Regular hours. Apply Dominion Glass Co. Ltd., Redcliff, Alta.

General Duty Nurses (2) for 60-bed hospital. 48-hr. wk. Salary: $140 per mo. with 3 annual increments of $5.00. Full maintenance. 4 wks. vacation at end of 1 yr. service. Apply Supt., General Hospital, Goderich, Ont.

British Columbia Civil Service requires: ***Registered Nurses for General Staff Duty for the Division of Tuberculosis Control***—*Vancouver Unit:* 225-bed T.B. Hospital, located at 2647 Willow St., Vancouver. All major services & student affiliation course. Registration in B.C. required. Gross salary: $182 per mo. Annual increments of $60 (over 5-yr. period). No residence accommodation. *Tranquille Unit:* 350-bed T.B. Hospital, located 12 miles from Kamloops in southern interior. All major services except student affiliation. Gross salary: $188.50 per mo. Annual increments of $60 (over 5-yr. period). New modern residence; attractive bed-sitting rooms. Recreational facilities. Main tenance deduction: Room $5.00; laundry $2.50. Excellent food at 20 cts. per meal. ***Conditions—Both Units:*** 8-hr. day, 5½-day wk. rotating shifts. 4 wks. annual vacation with pay plus 11 statutory holidays. Sick leave, 20 days per yr. (14 cumulative). Promotional opportunities. Superannuation. Write for information & applications to Supt. of Nurses in respective Units or to Director of Nursing, Division of T.B. Control, 2647 Willow St., Vancouver 9, B.C.

Dietitian for 400-bed hospital. Must be graduate of recognized School of Dietetics. Apply Miss Elizabeth S. Bayley, Chief Dietitian, General Hospital, Saint John, N.B.

Dietitian for 100-bed hospital. Salary depends on experience & qualifications. For particulars apply Supt., Soldiers' Memorial Hospital, Campbellton, N.B.

General Duty Nurses for 430-bed hospital. 44-hr. wk. 11 statutory holidays. Salary: $175-213 plus $20 C.O.L. Credit for past experience. Annual increments. Cumulative sick leave. 28 days annual vacation. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

Asst. Supervisor for Operating Room of 450-bed General Hospital. Apply, stating qualifications & salary expected, Director of Nursing, General Hospital, Saint John, N.B.

Registered Nurses (2) immediately for 3-year-old hospital. 21 adult beds plus 7 bassinets & children's beds. Salary: $150 per mo. plus full maintenance. 8-hr. day, 6-day wk. 1 mo. holiday with salary per annum. Private rooms in nurses' residence. Good train connection daily except Sun. to Regina & Saskatoon. Wire or phone collect Matron, Union Hospital, Leroy ,Sask.

General Duty Nurses. Salary: $155 less $25 for full maintenance. Increases of $5.00 after 6 mos. & at end of 1st yr. 8-hr. duty. Fare beyond 200 miles refunded. 2 wks. sick leave & 1 mo. holiday with pay—all after 1 yr. service. **Evening Supervisors.** Salary: $185 less $25 full maintenance. Fare, sick leave & holiday as above. Apply Supt., General Hospital, Kenora, Ont.

Operating Room Nurses (experienced). Beginning salary dependent on previous experience. Substantial semi-annual increase 1st yr. & annually thereafter for 3 yrs. Basic beginning salary for inexperienced **Registered Nurse,** $147.50 plus 2 meals & laundry. 48-hr. wk. Straight shift. Evening & night shift differential. Sick leave. Statutory holidays. 14 days vacation 1st yr. & 1 mo. thereafter. **Science Instructor** for 1952-53 (experienced with B.Sc. required). Beginning salary dependent on experience & qualifications. Monetary recognition for B.Sc. **General Duty Nurses.** Basic beginning salary, $147.50 plus 2 meals & laundry. Apply Supt. of Nurses, General Hospital, Winnipeg, Man.

General Staff Nurses. 44-hr. wk, 8-hr. day. Gross monthly salary: $193.50 ($210.50 less perquisites—2 meals & laundry, $22.50). Apply Director of Nursing, Civic Hospital, Ottawa, Ont.

Registered Nurses for 250-bed approved hospital. 40-hr. wk. $215 base pay. Additional $20 for evening duty & $10 for nights. $5.00 increase every 6 mos. until $50. Mo. paid vacation per yr. Apply Director of Nursing Service, St. Elizabeth Hospital, Yakima, Washington.

Graduate Nurses for General Duty on medical, surgical & obstetrical floors. 83-bed hospital located near Chicago. Apply Personnel Director, Highland Park Hospital, Highland Park, Illinois.

Supervisor for Pediatric Dept. Salary: $160 plus maintenance. 28 days vacation. **Registered Nurses for General Duty** in 200-bed hospital. Salary: Days, $140; evenings, $150; nights, $145—plus maintenance. 21 days vacation. Increments & cumulative sick leave. **Certified Nursing Assistants.** Salary: $100 plus maintenance. 21 days vacation. For further information apply Director of Nursing, County General Hospital, Welland, Ont.

General Duty Nurses for 350-bed Tuberculosis Hospital in centre of Laurentian summer & winter resort area, 2 hrs. from Montreal. Starting salary: $125 per mo. plus full maintenance. Attractive working hrs. with 1½ days off weekly & 1 week-end each mo. 1 mo. annual vacation. 14 days sick leave. Apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Que.

Supt. of Nurses for Royal Inland Hospital (with Training School), Kamloops, B.C. Apply, stating qualifications, experience & references, H. S. Wodlinger, Chairman of the Board, 27 Victoria St. W., Kamloops, B.C.

Registered Nurses for General Staff at Ontario Hospitals in Brockville, Hamilton, London, New Toronto, Orillia, Smiths Falls, St. Thomas, Toronto, Whitby, Woodstock. Initial salary: $1,840 per annum plus $300 Cost of Living Bonus, less prequisites ($26.50 for room, board, laundry). Annual increment, cumulative sick leave, superannuation, 3 wks. vacation, statutory holidays & special holidays with pay. 8-hr. day, 44-hr. wk. Apply Supt. of Nurses at above hospitals.

Public Health Nurse for generalized program in Belleville. Salary: $2,200-2,500 with annual increase of $100. Allowance for experience. Usual employee benefits. Apply Sec., Board of Health, Belleville, Ont.

Registered Nurse or Undergraduate Nurse for General Duty in small hospital in S.W. Sask. Good salary with full maintenance. Apply Sec.-Treas., Municipal Hospital, Frontier, Sask.

Dietitian (qualified). Opportunities for advancement. Teaching hospital. Full maintenance. Fare paid when accepted. Write, giving full particulars & when available, to Matron, King Edward VII Memorial Hospital, Bermuda.

British Columbia Civil Service requires a **Senior Instructor of Nursing** for the School of Psychiatric Nursing, Essondale, B.C. Salary: $258 rising to $308 per mo. (including Cost of Living Bonus). Qualifications: Candidates must be eligible for registration in British Columbia & have a University degree or certificate course in teaching & supervision, preferably with post-graduate study & experience in psychiatric nursing; must be capable of administration & supervision of a psychiatric nursing education program (diploma, affiliate & post-graduate courses). Candidates must be British subjects, under 40 yrs. of age except in case of ex-service women who are given preference. Further information & applications may be obtained from Director of Nursing, Provincial Mental Hospital, Essondale, B.C. or B.C. Civil Service Commission, Weiler Bldg., Victoria, B.C.

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For information apply to:

Director of Nursing
Royal Victoria Hospital
Montreal 2, Que.